MEDICARE ANNUAL REPORT TO CONGRESS

Fiscal Year 1990

Including the Report on the
Medicare Validation Surveys of Hospitals
Accredited by
The Joint Commission of Accreditation
of Healthcare Organizations

U.S. Department of Health and Human Services
Health Care Financing Administration

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Introduction

Medicare is a Federal health insurance program for people age 65 or older, certain younger disabled people, and people of any age with permanent kidney failure. The program is administered by the Health Care Financing Administration (HCFA) of the U.S. Department of Health and Human Services (HHS).

Enacted into law in July 1965 and inaugurated a year later, Medicare has two parts: Hospital Insurance (Part A) and Supplementary Medical Insurance (Part B). Hospital Insurance helps pay for medically necessary care provided by a Medicare-approved hospital, skilled nursing facility, home health agency, or hospice program. Supplementary Medical Insurance helps pay for medically necessary doctor services, outpatient hospital services, certain home health care services, and various medical services and supplies not covered by Medicare Hospital Insurance. Hospital Insurance is financed through the Federal Insurance Contributions Act (FICA) tax paid by employees, employers and the self-employed. Medical Insurance, which is voluntary, is financed from the monthly premiums paid by enrollees and from Federal general revenues.

Payments for services and supplies provided to Medicare beneficiaries are made through private insurance organizations under contract with the Federal government. Hospital Insurance claims are handled by Medicare "fiscal intermediaries," and Medical Insurance claims by Medicare "carriers."

Medicare benefit payments totaled $107.4 billion in Calendar Year (CY) 1990, an increase of 13.9 percent over FY 1989. During this period Medicare accounted for 18.6 percent of all personal health care expenses in the country, including 26.5 percent of all hospital care and 23.9 percent of all payments for physician services.

Medicare outlays represented a large share of national health expenditures, which totaled $670.9 billion in FY 1990, an increase of 11.1 percent from FY 1989. As a share of the gross national product (GNP), these expenditures climbed to 12.3 percent in FY 1990, increasing from 11.6 percent in FY 1989, and from 9.1 percent in FY 1980. At the same time, per capita spending increased to a level of $2,585, nearly 13 times the per capita spending of 1965.

Abbreviations and Acronyms

AAPCC ..... Adjusted average per capita cost
ADLS ..... Activities of daily living
AFDC ..... Aid to Families with Dependent Children
AHCCCS ..... Arizona Health Care Cost Containment System
AID ..... Acquired immune deficiency
AIDS ..... Acquired immune deficiency syndrome
ATB ..... All trunks busy
BITS ..... Beneficiary Inquiry Tracking System
BMAD ..... Part B Medicare annual data
BPD ..... Bureau of Policy Development
CAP ..... College of American Pathologists
CASR ..... Contractor Auditing and Settlement Report
CMP ..... Competitive medical plan
COBRA ..... Consolidated Omnibus Budget Reconciliation Act
COP ..... Conditions of participation
CPEP ..... Contractor performance evaluation program
CPT ..... Claims processing timeliness
CRNA ..... Certified Registered Nurse Anesthetists
CSI ..... Computerized severity index
CWF ..... Common working file
DCG ..... Diagnostic cost group
DME ..... Durable medical equipment
DOJ ..... Department of Justice
DRG ..... Diagnosis related group
EAP ..... Employee Assistance Program
EKGs ..... Electrocardiographic
EEO ..... Equal Opportunity Employment
EMC ..... Electronic media claim
ESRD ..... End-stage renal disease
EUC ..... End-user computing
FICA ..... Federal Insurance Contributions Act
FIs ..... Fiscal intermediaries
FY ..... Fiscal year
GHP ..... Group health plan
HCFA ..... Health Care Financing Administration
HCPCS ..... HCFA Common Procedure Coding System
HCPPs ..... Health care prepayment plans
HHA ..... Home health agency
HHS ..... U.S. Department of Health and Human Services
HMO ..... Health maintenance organization
ICF ..... Intermediate care facility
JCAHO ..... Joint Commission on Accreditation of Healthcare Organizations
LGHPs ..... Large groups health plans
LSC ..... Life Safety Code
MCCA ..... Medicare Catastrophic Coverage Act
MIGs ..... Medicare insured groups
MSP ..... Medicare Secondary Payer Program
NAIC ..... National Association of Insurance Commissioners
NDG ..... National Design Group
NDM ..... Network Data Mover
NDRR ..... National Data Reporting Requirements
NTIS ..... National Technical Information Services
OBRA ..... Omnibus Budget Reconciliation Act
ORD ..... Office of Research and Demonstrations
PICS ..... Plan Information Control System
P.L. ..... Public law
PMTT ..... Programmable Magnetic Tape Terminal
POS ..... Point of sale
PPS ..... Prospective payment system
PRISM ..... Project to Redesign Information System Management
PRO ..... Peer Review Organization
QA ..... Quality assurance
R&D ..... Research and demonstrations
RHHI ..... Regional home health intermediaries
SA ..... State agencies
SBIR ..... Small Business Innovative Research
SNF ..... Skilled nursing facility
TEFRA ..... Tax Equity and Fiscal Responsibility Act
UPIN ..... Unique Physician Identification Numbers
VAN ..... Value Added network

Executive Summary

Beneficiaries

During FY 1990, the number of Medicare beneficiaries increased by approximately 624,000, from 33.6 million to 34.2 million. Of the total number of beneficiaries, 33.5 million were residents of the United States, 437,000 lived in U.S. commonwealths and territories, and 268,000 resided in other countries.

Fully 94.4 percent (29.2 million) of the aged and 90.4 percent (2.9 million) of the disabled were enrolled in both Medicare Hospital Insurance (Part A) and Medicare Supplementary Medical Insurance (Part B). Approximately 95.2 percent of the Medicare enrollees residing in the 50 states and the District of Columbia were covered by both parts.

Benefit Payments

Medicare benefit payments totaled about $107.4 billion in FY 1990, or 13.9 percent more than the benefit outlays for the previous fiscal year. Benefits paid under the Hospital Insurance program amounted to $65.9 billion, while those paid under the Supplementary Medical Insurance program totaled $41.5 billion. Inpatient hospital care accounted for $59 billion, or 89.8 percent of Part A spending. Physician services, at nearly $29 billion, and independent laboratories, at $1.4 billion, accounted for more than 73 percent of Part B spending during the fiscal year.

Program Funding

In FY 1990, 88.8 percent of the financing for Medicare Part A was derived from employment taxes paid by workers and their employers and by self-employed individuals. The remainder came from Federal general revenues and other sources. Part B was financed by three sources: (1) premium payments from enrollees (24.9 percent); (2) contributions from general revenues (72 percent); and (3) interest on balances in the SMI Trust Fund (3.1 percent). The Part B monthly premium was $28.60 in CY 1990.

Health Care Providers

At the close of the fiscal year, 5,549 short-stay and 297 long-stay hospitals with about 1.2 million beds were participating in Medicare, as were 8,937 skilled nursing facilities (SNFs), 186 comprehensive outpatient rehabilitation facilities, 5,730 home health agencies (HHAs), and 4,879 independent laboratories. Other participating health care providers included 1,197 ambulatory surgical centers, 825 hospices, 551 rural health clinics and 1,937 end-stage renal disease (ESRD) facilities or units providing services to Medicare beneficiaries requiring maintenance dialysis or kidney transplants.

Participating Physicians and Medical Suppliers

About 47.6 percent of the physicians (329,008) and 22.6 percent of the medical suppliers (27,445) serving Medicare beneficiaries signed participation agreements with HCFA for CY 1990. Physicians and suppliers may choose each year to participate in Medicare and to accept assignment on all Medicare claims. Participating physicians and suppliers agree to accept Medicare approved amounts as payment in full for their services regardless of the actual charges. Beneficiaries are responsible only for applicable deductible and coinsurance amounts. As of September 1, 1990, physicians were required to submit unassigned claims to Medicare carriers on behalf of beneficiaries.

Quality of Care Monitored

Peer Review Organizations (PROs) under the aegis of HCFA concentrated during the fiscal year on monitoring the quality of care afforded Medicare beneficiaries and ensuring compliance by Medicare providers with the provisions of the prospective payment system (PPS). Major areas scrutinized by the PROs included hospital admissions, readmissions and transfers, accuracy of coding, and day and cost outlier cases. PROs identified 231 physicians and 39 providers with potential sanctionable violations during the fiscal year and sent 194 notices informing them of the possibility of being sanctioned. Sanctions imposed by the Office of Inspector General resulted in 13 physicians being excluded from the Medicare program for varying periods of time. One physician retired prior to the implementation of a monetary penalty.

Prepayment Plan Option Emphasized

HCFA maintained emphasis throughout the year on the importance of providing Medicare beneficiaries with an alternative to traditional fee-for-service health care by promoting prepayment health plans as an option for beneficiaries to consider in determining how they will receive Medicare-covered services. By the end of the fiscal year, the number of health maintenance organizations (HMOs), and competitive medical plans (CMPs), with HCFA risk-based was 97. At the same time, the number of beneficiaries enrolled in prepayment plans rose to 1,216,617, an increase of nearly 10 percent over the FY 1989 figure.

Medicare Claims

Medicare intermediaries received 83.6 million claims in FY 1990, an 8.7 percent increase over FY 1989, and Medicare carriers received 457.4 million, a 10.1 percent increase. Both Part A and Part B Medicare contractors were generally successful in meeting the deadlines for the timely payment of Medicare claims. Contractors were required as of the beginning of the fiscal year to pay at least 95 percent of all "clean" Medicare claims within 24 days. They were required to pay 95 percent of all claims within 60 days and 99 percent of all claims within 90 days. Claims submitted by physicians who signed agreements to participate in Medicare were to be paid within 17 days.

Operational Reviews

Operational reviews undertaken during the fiscal year included a review of the effectiveness of nationally mandated and local carrier review screens, a review of the adjudication process for peer review organization (PRO) denials/adjustments, and a review of the medical necessity and reasonableness of payments for certain Medicare hospital outpatient services. Physician global service package studies for selected surgeries were continued during the fiscal year and four new global service package studies were implemented.

Ensuring that Medicare payment is made only for reasonable and necessary physician services is the responsibility of the Medicare carriers. Carriers execute this responsibility through a blend of prepayment reviews of individual services and postpayment reviews of utilization patterns of physician and supplier services. The carrier determination is based on national coverage policy in association with local policy developed by the carrier medical staff. This activity has been cost-effective, with FY 1990 program savings of about $9 for each administrative dollar expended.

Medicare Secondary Payer Provisions

The Medicare Secondary Payer (MSP) provisions, which cost $65.4 million to administer, produced more than $2.5 billion in savings. The provisions determine when Medicare is a secondary payer and another insurer is the primary payer of a Medicare

beneficiary's claims for covered medical services and supplies. Other Medicare payment safeguards accounted for $2.7 billion in savings during the fiscal year.

Contractor Performance Evaluation Program

The Contractor Performance Evaluation Program (CPEP) contains performance standards designed to prevent the inappropriate expenditure of Medicare funds. During FY 1990, 60 standards were applied to measuring the performance of fiscal intermediaries and 75 standards were applied to carriers. Fifty-two of the 54 intermediaries and 38 of the 48 carriers met the CPEP standards. The 10 carriers that failed to meet the standards were required to implement plans to improve their performance.

$15.5 Million for 238 New Projects

Research, demonstration, and evaluation projects were conducted during the fiscal year in the areas of reimbursement, coverage, eligibility and program management approaches, as well as research and evaluation studies of the impact of HCFA programs on quality health care services and the economics of the health care industry. HCFA spent over $49 million during the fiscal year for grants and contracts to conduct research, demonstration, and evaluation projects. Of this amount, $33.6 million went to the approximately 300 studies that continued into FY 1990 from previous years. An additional $15.5 million went to fund 238 new projects, including $9.4 million awarded to 211 hospitals under the Rural Health Care Transition Grant Program.

Validation Surveys of Hospitals

The purpose of the Medicare validation program is to determine the effectiveness of the Joint Commission on Accreditation of Healthcare Organizations (Joint Commission) accreditation process in providing reasonable assurance that hospitals comply with the intent of the Medicare conditions of participation. Each year a statistical sample of the approximately 5,200 Joint Commission accredited hospitals is selected for validation surveys. Under contract with the Secretary of HHS, Medicare State survey agencies (SAs) conducted 194 sample validation surveys during fiscal year 1990 and investigated 695 complaints which led to 35 full allegation surveys. HCFA's validation analysis was conducted in two areas: Life Safety Code (LSC) and general health and safety requirements. The LSC of the National Fire Protection Association is a consensus standard adopted by reference in Federal regulations that provides a reasonable level of safety from fire and emergencies. During the fiscal year, 11.3 percent (22 of 194) of validated hospitals had major LSC deficiencies.

Chapter I

The Medicare Population and Benefits

Introduction

Medicare enrollment increased 1.8 percent in FY 1990 from 33.6 million to 34.2 million, and benefit outlays rose 13.9 percent from $94.3 billion to $107.4 billion. One out of every eight Americans had some Medicare coverage during the fiscal year, which means that the Medicare program covered about 13.9 percent of the United States resident population of 245.8 million.

Medicare Beneficiaries

Approximately 624,000 individuals were added to the Medicare rolls during the year. Some 540,000 of the new enrollees were65 years of age or older, bringing to 30.9 million the number of elderly beneficiaries, and 84,000 were younger disabled persons, increasing the number of disabled beneficiaries to 3.3 million. Included among the disabled were 65,000 with end-stage renal disease who must meet eligibility requirements different than those for other disabled beneficiaries.

Of the approximately 34.2 million beneficiaries, 33.5 million were residents of one of the 50 States or the District of Columbia, 429,000 resided in Puerto Rico, 7,300 in the Virgin Islands, 890 in Guam, and 261 in American Samoa, the Northern Mariana Islands and other outlying areas. Another 268,000 resided in foreign countries. Ninety-five percent of the Medicare population in the 50 states and the District of Columbia, 66 percent of the beneficiaries in U.S. commonwealths and territories, and 16 percent of the beneficiaries in foreign countries were enrolled in both Medicare Part A and Part B.

Women accounted for 57.7 percent of the total Medicare population, 59.9 percent of the beneficiaries 65 years of age and older, and 37.2 percent of the disabled enrollees. The percentage of disabled who are men, while down slightly in

FY 1990 to 62.8, has remained relatively constant since FY 1980 as has the percentage of aged who are men. Minorities represent a growing proportion of the Medicare population. In FY 1990, 3.8 million Medicare enrollees were other than white. This represented 11.5 percent of the Medicare population, a rise of 3 percent over FY 1989 and an increase of 1.6 percent over FY 1980 when 9.9 percent of beneficiaries were non-white. While non-whites made up only 10.4 percent of aged beneficiaries, 22.3 percent of the disabled beneficiaries were other than white, an increase of nearly 1 percent over the figure for the previous fiscal year.

A significant demographic trend that has and will continue to affect Medicare is the increasing median age of beneficiaries. In FY 1973, about 1.7 million beneficiaries, or 7.8 percent of the elderly population, were 85 and older. In FY 1990, 3.3 million, or 10.6 percent of the aged population, were in the 85-and-over category. The aging of the Medicare population is an important economic factor as older beneficiaries generally require greater and more intense health care services than do younger beneficiaries.

Benefit Expenditures

Medicare benefit payments for FY 1990 totaled about $107.4 billion, or 13.9 percent more than for the previous fiscal year. Benefits paid under Medicare Hospital Insurance (Part A) increased 14.8 percent, while those paid under Medicare Supplementary Medical Insurance (Part B) increased 12.6 percent. Benefit payments for FY 1990 were broken down as follows:

- Hospital Insurance (Part A)—$65.9 billion
- Supplementary Medical Insurance (Part B)—$41.5 billion

Part A spending was divided among its components as shown in Table 1. Of all purchases, hospital care, at $59.2 billion, accounted for the largest portion of Medicare spending during the fiscal year. Nearly 55 percent of Medicare's total benefit expenditures and nearly 90 percent of Part A outlays went for inpatient hospitalization. Medicare beneficiaries are entitled to 90 days of inpatient hospital care in each benefit period. A benefit period begins the first day a beneficiary receives Medicare-covered services in a hospital. It ends when the beneficiary has been out of the hospital or skilled nursing facility for 60 consecutive days. There is no limit to the number of benefit periods a beneficiary can have. In addition to the 90 days of inpatient hospital care, a beneficiary also has 60 "lifetime reserve days" which can be used whenever more than 90 days of hospitalization are required. Once used, lifetime reserve days are not renewed.

Medicare paid $2.8 billion for skilled nursing facility (SNF) services in FY 1990, or about 23 percent more than in the last fiscal year. The cost of SNF services accounted for nearly 5 percent of Part A outlays during the year. Medicare beneficiaries are entitled to 100 days of SNF care during a benefit period, provided the SNF admission follows an inpatient hospital stay of at least three consecutive days and certain other conditions are met.

The $3.6 billion spent on home health services during the fiscal year was 45.4 percent higher than home health outlays in FY 1989. However, it accounted for only 5.5 percent of Part A spending. Part A covers home health visits with no prior hospitalization requirement. The care needed must include part-time or intermittent skilled nursing care, physical therapy or speech therapy, and the patient must be homebound.

For the third consecutive fiscal year, the greatest percentage increase in any single category of Medicare spending was for hospice care, which increased 51.7 percent, from $211 million in FY 1989 to $320 million. However, hospice care accounts for less than 1 percent of Part A benefit payments. The rise was primarily due to the growing popularity of hospice care, which accounted for $4 million in Medicare spending when it was introduced as a benefit in 1984. Part A of Medicare pays for hospice care when a physician certifies that a patient is terminally ill; the patient chooses hospice care instead of standard Medicare benefits for the terminal illness; and care is provided by a hospice program approved by Medicare.

Table 1

Benefit	FY 1989	FY 1990	%Change
Inpatient Hospital	$52,461	$59,165	7.0
Skilled Nursing Facility	2,253	2,781	23.4
Home Health	2,508	3,646	45.4
Hospice	211	320	51.7
TOTAL	**$57,433**	**$65,912**	**14.8**

Supplementary Medical Insurance

Part B, which, at $41.5 billion, was 12.6 percent higher than in FY 1989, was broken down as shown in Table 2.

The $29 billion spent for physician services was 10.7 percent more than the FY 1989 outlay and represented nearly 69.8 percent of Part B spending for the fiscal year. Part B generally pays 80 percent of Medicare-approved charges for medical services after the beneficiary pays the first $100 in approved charges each calendar year. Medicare spending for outpatient services increased from $7.3 billion in FY 1989 to $8.3 billion. Outpatient services provided by hospitals are covered under Part B.

The 19.4 percent increase in outlays for group practice plans, rising from $2.2 billion to $2.6 billion, reflects the increased number of Medicare beneficiaries enrolled in prepayment plans, such as health maintenance organizations (HMOs) and competitive medical plans (CMPs). This category of expenditures is only 6.4 percent of total Part B expenditures. The 27.8 percent increase in home health benefit outlays was the second highest percentage increase of the Part B components, rising from $72 million to $92 million. However, this represented a relatively small share of total Part B spending because most home health care is covered by Medicare Part A. Also climbing significantly was the percentage of Part B spending for independent laboratory services, jumping 31.5 percent from $1 billion in FY 1989 to $1.1 billion in FY 1990.

Providers

The number of participating hospitals rose from 6,508 in FY 1989 to 6,520 in FY 1990. During the same period, the number of short-stay hospitals slipped from 5,582 to 5,549 while the number of long-stay hospitals increased from 290 to 297. At the same time, the number of psychiatric hospitals increased from 636 to 674.

There were 314 discharges per 1,000 beneficiaries in FY 1990 compared with 315 discharges per 1,000 beneficiaries for the previous 12-month period. Moreover, the 2,811 days of care per 1,000 enrollees in FY 1990 were 31 fewer than in FY 1989. The average length of a hospital stay was 8.9 days, up from 8.8 days in FY 1989.

During the fiscal year, the number of SNFs rose from 8,198 to 8,937, and the number of SNF beds increased by about 10,000 to 509,000. The number of home health agencies was 5,730 compared to 5,546 in FY 1989.

Other providers participating in Medicare during the fiscal year included 4,879 independent laboratories, 1,937 end-stage renal disease (ESRD) facilities, 186 comprehensive outpatient rehabilitation facilities, 1,197 ambulatory surgical centers and 825 hospices.

Table 2

Benefit	FY 1988	FY 1989	% Change
Physicians	$24,243	$26,176	8.0
Outpatient Services	6,452	7,307	13.3
Group Practice	1,952	2,218	13.6
Independent Laboratory	975	1,096	12.4
Home Health	60	70	16.7

Program Funding

Under the Social Security Act, the Federal Hospital Insurance (Part A) and the Federal Supplementary Medical Insurance (Part B) Trust Funds are administered by two boards of trustees, each with the same five members. Three members serve in an ex officio capacity:

- The Secretary of Treasury, who by law serves as managing trustee of both funds
- The Secretary of Labor
- The Secretary of Health and Human Services.

Two public members are nominated by the President for four-year terms subject to confirmation by the Senate. The Administrator of HCFA serves as secretary of both boards.

The primary source of Part A financing (88.8 percent) was derived from payroll taxes paid by workers and their employers and by self-employed individuals. The remainder came from Federal general revenues for certain insured individuals who attained age 65 before 1975, premium payments for voluntarily enrolled individuals, transfers from the Railroad Retirement Board, military service credits, and interest on accumulated funds.

Part B was financed by three sources: (1) premium payments from enrollees, (2) contributions from general revenues, and (3) interest on trust fund reserves. The Part B premium under the Tax Equity and Fiscal Responsibility Act and the Deficit Reduction Act was set at 25 percent of program costs. In FY 1990, beneficiary premiums covered 24.9 percent, and government contributions 72 percent, of the cost of Part B. Interest on trust fund reserves covered the balance.

More detailed information about the status of the trust funds, showing income, disbursement and future projections, is contained in the 1990 annual reports of the trustees of the respective funds.

Chapter II

Utilization and Quality Control Peer Review Organization Program

Introduction

Section 1161 of the Social Security Act (the Act) requires HCFA to give Congress a full and complete annual report on the administration, impact, and cost of the Utilization and Quality Control Peer Review Organization (PRO) Program. This report includes the following items mandated by section 1161 of the Act:

(1) statistics on PROs participating in the program,
(2) the institutions/physicians/beneficiaries subject to PRO review,
(3) the methods of reimbursement for PRO contracts, and the relative efficiency of such methods,
(4) the number of penalties and sanctions imposed,
(5) total Federal expenditures, and
(6) criteria for review.

The PROs are charged by law to ensure that services rendered to Medicare beneficiaries meet professionally recognized standards of care and are medically necessary and provided in the most appropriate setting (e.g., acute care hospital vs. skilled nursing facility (SNF) or a lesser level of care). Most PRO review is done restrospectively, that is after the patient has been discharged from the hospital, amubulatory surgical center, or other setting. In this case, after the beneficiary is discharged from the hospital and payment is made to the hospital, paid bill data are sent by the fiscal intermediary to the PRO. The PRO selects a sample for review and requests the relevant medical records from the hospital.

First-level PRO reviewers, primarily nurses, use criteria for review which are developed by local practicing physicians to approve payment for cases which clearly meet acceptable standards. They refer questionable cases to PRO physician reviewers. If the physician reviewer determines that there is a potential utilization or quality problem, the PRO will offer the physician or other provider an opportunity to discuss the case and submit additional information, if any is available.

If the PRO physician reviewer determines that the care was not medically necessary or that it should have been provided in another setting, the PRO will issue a payment denial. It should be noted that only the PRO physician reviewer may deny a case, and denials may be made only after the physician or provider has been given an opportunity to discuss the case with the PRO. If, after the discussion, the PRO physician reviewer determines that there is a confirmed quality problem, the PRO will initiate corrective action.

Statistics on PROs Participating in the Program

In FY 1990, all 53 PROs were under the third scope of work (SOW) with 3-year contracts (a PRO in each of the 50 States, District of Columbia, Puerto Rico, and the Virgin Islands). Of these 53 areas, the contracts for 11 areas are held by a PRO in another State, with review actually being performed by physicians practicing in the State. (For example, Rhode Island has the contract for the State of Maine but utilizes physicians practicing in Maine.) In FY 1990, HCFA competed only 1 PRO contract area (New York); the competition was necessitated by the nonrenewal of the former PRO.

Institutions/Physicians/Beneficiaries Subject to PRO Review

A sample of Medicare admissions in 6,554 acute and 914 specialty hospitals was reviewed by the PROs during the fiscal year for appropriate utilization and quality of care. In addition, PROs performed utilization and quality reviews of ambulatory surgery performed in ambulatory surgical centers (1,234) and hospital outpatient areas (6,554). PROs also performed:

- Quality reviews, on a sample basis, of SNF (9,191) and home health services (5,774);
- Quality reviews of services rendered to Medicare enrollees in risk-based HMOs/CMPs;
- Preadmission/preprocedure reviews of all cases that included any 10 procedures identified as requiring prior authoriation; *and*
- Reviews of the care provided to beneficiaries who filed quality-of-care complaints.

The PROs completed about 4,074,600 reviews in FY 1990. They denied 2.9 percent of the cases reviewed retrospectively and in about 0.2 percent of the cases requiring preadmission or preprocedure authorization. There were more than 750,000 cases that failed one or more generic quality screens. Of those, more than 21,000 were confirmed as quality problems. Although every physician who treats hospitalized Medicare beneficiaries has cases that are subject to review, PROs did not specifically review physician services rendered in the office setting during FY 1990.

Method of Reimbursement for PRO Contracts

Fifty-two of the 53 PROs had variable, fixed-price contracts. The variable contract has a fixed-price for the accomplishment of a specified task or product, but varies with the number of such items produced. For these contracts, HCFA paid a fixed negotiated amount each month for a PRO's administrative costs, which included the cost of overhead and other nonreview activities, and a separate reimbursement amount for each individual type of completed review (i.e., simple, complex, and ambulatory).

The total amount HCFA paid the PROs under these contracts was based on the number of completed reviews they performed in each category, with an upper limit specified in the contract plus the fixed monthly amount. HCFA also paid the PROs for photocopy and postage expenses related to medical records requested by PROs, and for the cost of pilot studies and developing sanction cases. In addition, HCFA paid each PRO a one-time cost for the development and implementation of a new PRO cost reporting system. The other PRO (Hawaii) was paid under a cost reimbursement contract with a limit on the total expenditures allowed.

Penalties and Sanctions

PROs identified 231 physicians and 39 providers with potential sanctionable violations during FY 1990 and sent 194 notices informing them of the possibility of being sanctioned. In a related action, the Office of Inspector General imposed 14 sanctions, with the result that 13 physicians were excluded from the Medicare program for varying periods of time, and one physician retired prior to implementation of a monetary penalty.

Total Federal Expenditures

The total funds expended in FY 1990 for PRO Medicare required reviews were $290.1 million, consisting of $0.8 million for extensions of second round contracts and $289.3 million for third round contracts. The total amount expended in FY 1990 for pilot studies was $5.4 million.

Under Title XIX of the Social Security Act, States may (at their option) contract with PROs to review Medicaid services. If a State contracts with a PRO, the State receives

Federal financial participation (FFP) funding at 75 percent of the cost of that review. In FY 1990, 36 PROs had contracts to review Medicaid services. The total amount expended by States under these contracts for Medicaid review was $33,246,087. The total FFP expenditures were $24,934,561 (Table 3).

Table 3

PROS WITH CONTRACTS TO REVIEW MEDICAID SERVICES

STATE	TOTAL AMOUNT	FFP AMOUNT	STATE EXPENDITURE
Alaska	356,452	267,339	89,113
Arizona	311,539	233,654	77,885
Arkansas	1,018,886	764,164	254,722
Colorado	2,706,689	2,030,017	676,672
Delaware	148,924	111,692	37,232
DistrictofColumbia	420,279	315,209	105,070
Florida	768,844	576,633	192,211
Georgia	1,800,000	1,350,000	450,000
Idaho	232,620	174,465	58,155
Illinois	2,496,296	1,872,222	624,074
Iowa	2,927,257	2,195,443	731,814
Kansas	982,843	737,132	245,711
Kentucky	1,250,000	937,500	312,500
Maryland	2,009,008	1,506,756	502,252
Michigan	946,033	709,525	236,508
Mississippi	1,248,521	936,391	312,130
Montana	309,883	232,412	77,471
Nebraska	575,621	431,716	143,905
Nevada	504,408	378,306	126,102
NewHampshire	159,094	119,320	39,774
NewMexico	410,000	307,500	102,500
NewYork	5,345,482	4,009,111	1,336,371
NorthCarolina	225,708	169,281	56,427
NorthDakota	169,983	127,487	42,496
Ohio	271,574	203,680	67,894
Oklahoma	497,000	372,750	124,250
Oregon	129,226	96,919	32,307
PuertoRico	198,000	148,500	49,500
SouthCarolina	400,000	300,000	100,000
SouthDakota	32,571	24,428	8,143
Tennessee	1,485,500	1,114,125	371,375
Vermont	153,996	115,497	38,499
Washington	310,403	232,802	77,601
WestVirginia	1,007,079	755,310	251,769
Wisconsin	1,344,462	1,008,346	336,116
Wyoming	91,906	68,929	22,977
Total	**33,246,087**	**24,934,561**	**8,311,526**

Criteria for Review

Review criteria are screening tools used by PRO nonphysician reviewers that are developed by actively practicing physicians or adapted from nationally developed criteria that reflect typical practices in the local area. Review criteria contain the generally recognized reasons which would justify a patient's admission to a hospital or the need for a surgical procedure. The PRO screening criteria must be met in order for the PRO nonphysician reviewer to approve Medicare payment without physician review. Cases which fail to meet the criteria are referred to PRO physicians, who are actively practicing physicians in the PRO area. The physician reviewers make their determinations regarding the necessity, appropriateness, and quality of care for each questionable case primarily on the basis of their own knowledge, experience, and training and on the basis of discussions with the attending physicians.

In addition, all PROs apply discharge screens and the generic quality screens to all cases retrospectively reviewed under their contracts. The generic quality screens are specific to the type of setting the PRO is reviewing and are indicators used by nonphysician reviewers to identify cases of possible poor quality care. Any case that fails one or more of the screens and is a potential quality problem will be further evaluated by PRO physicians who will determine whether the care met professionally recognized standards of quality. These determinations are made on a case-by-case basis using the patient's medical record and any additional information available.

Chapter III

Encouraging Competition and Choice

Introduction

HCFA continued during FY 1990 to provide beneficiaries with an alternative to traditional fee-for-service Medicare through contracts with prepaid health plans such as health maintenance organizations (HMOs) and competitive medical plans (CMPs). During the fiscal year, the number of Medicare beneficiaries enrolled in HMOs and CMPs contracting on a risk basis continued to increase. As of September 1990, the number of beneficiaries enrolled in plans with risk contracts increased to 1,216,617, an increase of almost ten percent over FY 1989. This represents just over 3 percent of the total eligible population (or over 7 percent of the total eligible Medicare population in areas where a Medicare risk-based contract HMO or CMP is available). While HMO/CMP enrollment grew, the number of risk-based contracts declined. At the end of FY 1990 HCFA was contracting with 97 risk-based HMOs/CMPs in 27 states.

There were three risk-based contracts that were not renewed as well as two contracts that had service area reductions in FY 1990. In addition, eight HMOs/CMPs converted their risk-based contracts to another type of managed care arrangement. Beneficiary enrollment in the risk program continued to grow during FY 1990 despite the decrease in the number of risk contracts. A contributing factor in the decreased number of plans was a trend in the HMO industry of consolidations, acquisitions, and mergers. Much of the increase in Medicare HMO/CMP enrollment resulted from expansions of Medicare contract service areas by a number of existing risk contractors.

Prepaid Health Plan Organization and Costs

A prepaid health plan may generally be described as an organization that provides its members comprehensive health services in return for a predetermined, fixed monthly payment, or "premium," for each enrolled member. The premiums for commercially enrolled members of HMOs are often paid in whole or in part by an employer group which contracts with the organization for the provision of health care services to the members of the employer group. Under a Medicare risk contract, HCFA similarly makes a monthly payment to the organization for each Medicare beneficiary who enrolls in the HMO. The Medicare payment rate is determined annually and varies depending on the geographic area served by the HMO and certain particular characteristics of the enrolled beneficiaries (e.g., age, disability status).

In addition to the monthly capitation payments that HCFA makes on behalf of Medicare beneficiaries, individual Medicare enrollees of an HMO must generally pay a monthly premium to the organization, as well as nominal copayments for particular services received. These premiums and copayments cover the portion of physician and provider charges that is not covered by Medicare (e.g., 20 percent coinsurance for Part B services) and services that are not covered by Medicare. The Medicare statute sets an upper limit on the amounts an HMO may charge a beneficiary, based on the average expenses of beneficiaries across the country for Medicare-covered services and the amounts the HMO would charge its commercial enrollees for Medicare-covered services.

HMO/CMP Oversight

The Office of Compliance within HCFA's Office of Prepaid Health Care (OPHC) was responsible for monitoring the activities of all Federally qualified HMOs, and organizations with Medicare contracts, to assure that they complied with applicable requirements of Title XIII of the Public Health Service Act and Title XVIII of the Social Security Act.

OPHC monitoring strategy focused on the proactive identification of potential problems in HMOs/CMPs with Medicare contracts. In an effort to enhance this strategy, the office was working to improve the availability and use of HMO/CMP program data, and to improve OPHC's internal compliance operations by developing uniform procedures for HMO/CMP reviews.

On-Site Monitoring Review

During FY 1990, OPHC and the HCFA Regional Offices conducted 55 monitoring site visits. These routine biennial visits assess regulatory and contractual requirements related to the contractor's overall operations, as well as the ongoing capability of the contractor to fulfill the terms of the Medicare contract. A national standardized review guide has been developed to assess contractor performance in nine areas. The guide is updated annually to reflect ongoing program changes.

This is the fourth year that OPHC and the HCFA Regional Offices have conducted the reviews. OPHC is continuing to conduct corporate visits to entities which have multiple affiliates throughout the country which contract with HCFA. These visits have been conducted to determine the level and extent of functions that these multi-state entities perform for their affiliates. OPHC has determined that the visits to the corporate offices, as well as the operational affiliates, have provided information vital to the compliance process.

OPHC identified deficiencies at the majority of sites visited during FY 1990. These deficiencies were reported to the HMO/CMP for corrective action. Many of the deficiencies were minor and were corrected during the course of the visit. Other deficiencies required corrective action plans (CAPs). These CAPs are submitted to OPHC by the contractor and monitored until the contractor remedies the deficiencies. When the deficiency is of a serious nature, the Office of Compliance initiates the formal regulatory compliance enforcement process - a more indepth investigation with a possible finding of noncompliance. Under a finding of noncompliance, the HMO/CMP is "directed" to correct the deficiency. Failure to correct a noncompliance deficiency could result in termination from the program. During FY 1990, the agency did not find it necessary to terminate any HMO/CMP under a noncompliance action.

Humana Health Maintenance Organizations

OPHC devoted significant resources to investigating the Humana HMOs' marketing activities during FY 1990. The Humana HMOs in Florida, Texas, Arizona, and Kentucky (which were all Medicare risk-based contractors at the time) were placed in the formal regulatory compliance enforcement process in January 1990. OPHC conducted investigation site visits to Humana's corporate offices as well as to five of Humana's marketing offices to gain information concerning marketing practices. Deficiencies in compliance with requirements for availability and accessibility, quality assurance, claims processing, and processing of grievances and appeals were noted in varying degrees at the marketing offices. After protracted negotiation beginning in FY 1990, Humana and OPHC reached agreement concerning necessary corrective action shortly after the close of FY 1990. At the end of FY 1990, approxi-

mately 215,000 Medicare beneficiaries were enrolled under risk-based Medicare contracts held by HMOs which were subsidiaries of Humana, Inc.

External Quality Review by PROs/QROs

Implementation of external quality review of HMO/CMP risk contractors by peer review organizations (PROs) and quality review organizations (QROs) began in 1988 and the volume of review continued to increase during FY 1989 and FY 1990. OPHC worked with HCFA's Health Standards and Quality Bureau (HSQB) to assure that risk contracting HMOs/CMPs cooperated with the PRO/QROs conducting external quality review. During FY 1990, several risk contractors were investigated due to their unwillingness to submit the requested medical records within the required timeframes. Corrective action plans were developed, approved, and monitored to remedy the situation.

The current method that PROs and QROs use to select samples of cases for quality review relies upon the data reported on the Medicare bill. These Medicare bills are used by hospitals to report when each Medicare beneficiary is discharged from the hospital. (This bill is not submitted for payment; it allows HCFA to account for utilization.) In addition, PROs/QROs use enrollee lists from the HMOs/CMPs to select their sample for focused ambulatory review and to sample lists of beneficiary enrollee deaths for their review of deaths.

Because these hospital bills are not used for HMO/CMP reimbursement purposes, there is no incentive for HMOs/CMPs or hospitals to submit these bills. This resulted in the volume of bills being much lower than predicted. This has made the current methodology less reliable than desired. In FY 1990, the volume of bills submitted to fiscal intermediaries increased over past years, but still fell short of projections. Thus, the required samples were not realized. As a result, HCFA implemented a plan to augment the sampling.

Improving the PRO Review Program

HCFA and HMO industry representatives began formulating ideas during the fiscal year on how to enhance the effectiveness of the PRO review program for risk-based coordinated care organizations. It was agreed that the program must ensure the integrity of the review process and maintain adequate beneficiary protection. The discussions began to evolve into short-term, and long-term proposals to change the current system. The short-term proposal would eliminate the use of the hospital bills as the data source used for PRO/QRO sample selections. HCFA could require the PRO/QRO to draw its sample from lists of enrollees. The HMO/CMP would then inform the PRO/QRO about which enrollees used services. In addition, the PRO/QRO would focus interventions on the investigation and, where necessary, correction of problems. The PRO/QRO would continue to evaluate all beneficiary complaints about access and quality, and review a sample of death cases.

The long-term proposal would involve the development of a standardized clinical data set by which each HMO/CMP would report beneficiary specific inpatient and ambulatory data. In addition, HCFA would solicit demonstrations which would evaluate methods to strengthen the internal quality assurance requirements for HMOs. HCFA may test an "accreditation" type of review similar to the Medicaid quality review process that some States employ. Final decisions about the proposed revisions to PRO/QRO external review are expected in early 1991.

Any improvements to the PRO/QRO external review will be executed through PRO contract modifications. HCFA expects 1991 to be the beginning of an improved approach to the external review of HMOs/CMPs assuring verifiable satisfactory quality assurance.

Coordinated Care Initiatives

In FY 1990, OPHC organized task forces and work groups to address certain complex issues in coordinated care:

Employer Group Task Force: As the cost of health care continues to escalate, employers are seeking comprehensive health care coverage at a reasonable cost for their retirees, as well as their active employees. Many employers are purchasing health care coverage for their retirees from HMOs that have contracts with the Medicare program. A major problem with this, however, is that HCFA works on a prospective payment system while most group transactions are retrospective.

In response to heightened interest from HMOs and employers in serving group retirees through Medicare HMO contracts, in April 1989, HCFA formed the Employer Group Task Force which continued to meet through FY 1990. All interested parties—beneficiaries, HMOs, employers, and Medicare—can benefit from an increase in coordination between employers and risk-contracting HMOs.

- Medicare beneficiaries who are enrolled in an HMO as part of a group generally have all or a portion of their monthly premium paid for by their former employer or union. They are able to maintain coverage with the same provider network with which they had been enrolled as active employees.
- HMOs can increase their enrollment through employer groups with lower marketing costs than required for individual enrollees.
- Employers can deal with one entity for both active employees and retirees and reduce costs relative to traditional fee-for-service Medicare "wrap-arounds" (supplemental policies).
- For Medicare, employer groups could be a way to substantially increase enrollment in the risk-based program.

With these benefits in mind, the Employer Group Task Force has worked to address the challenges and opportunities presented by employer group retiree enrollment in Medicare-contracting HMOs and CMPs. The Task Force worked toward three goals:

1) to identify barriers to increased enrollment in Medicare-contracting HMOs by retiree group members and to make recommendations to eliminate barriers that might prohibit further enrollment;
2) to inform HMOs and employers as to how to coordinate group retiree plans with individual Medicare enrollment; *and*
3) to better manage the Medicare HMO program as it relates to group retirees.

The Task Force, comprised of representatives from various components within HCFA, gathered information directly from those HMOs and CMPs which currently contract with employer groups. The Task Force also met with industry leaders and business groups to learn more about current practices regarding Medicare coverage of group retirees, and conducted site visits to selected HMOs to determine the size and nature of their difficulties in serving group retirees. In addition, the Task Force held a workshop with industry representatives to discuss problems associated with group retirees enrolled in Medicare HMOs and to elicit feedback on solutions to those problems. The Task Force also held an educational workshop to help HMOs understand how they might serve employer groups' Medicare-eligible retirees. There has been a great deal of industry interest in the Task Force's activities.

A final report has been prepared which summarizes the Task Force's work and includes recommendations to facilitate employer group contracts with Medicare-contracting prepaid health plans. One of the Task Force's recommendations, to permit retroactive enrollment for employer groups, was enacted in the Omnibus Budget Reconciliation Act of 1990 (OBRA-90).

Medicare Secondary Payer/Coordination of Benefits Work Group

With the maturation of the coordinated care option under Medicare, questions have arisen pertaining to enrollment of the working aged and coordination of benefits (COB). COB issues arise when working aged and other Medicare eligible individuals entitled to third party health care coverage enroll under risk-based contracts. The Medicare Secondary Payer/Coordination of Benefits (MSP/COB) Work Group was formed in May 1990 to determine where and to what extent MSP/COB legislation, regulations and manual issuances are required to provide equitable treatment for Medicare beneficiaries enrolled in Medicare's coordinated health care option when MSP/COB provisions apply. In the fee-for-service, or traditional Medicare program, MSP and COB issues have been more clearly defined and addressed. Therefore, the Work Group began by reviewing existing requirements in the fee-for-service and coordinated care programs, identifying differences, determining to what extent such differences between the two should be retained, and making recommendations for a "crosswalk" between the two programs. Represented on the Work Group are all major components within HCFA having an interest in MSP/COB issues.

One of the first issues reviewed by the Work Group was enrollment of working aged individuals in risk-based HMOs. The Work Group found that existing law does not deny Medicare beneficiaries, who are covered by an employer group health plan, the right to enroll in risk-based HMOs/CMPs. And further, the working aged individual could enroll under both plans (i.e., the employer's active worker/group health plan and the risk-based plan) at the same time.

Other complex issues related to enrollment of working aged individuals included an examination of whether the employer or the risk-based plan could pay the Part B premium for the Medicare enrollee. (Payment of the Part B premium is a prerequisite for enrollment of a Medicare beneficiary in a risk-based plan.) Another issue was whether it was reasonable to distinguish between an employer paying the Part B premium and its paying the HMO premium.

The Work Group has been diligent in coordinating its tasks with the efforts of the National Association of Insurance Commissions (NAIC). The NAIC has prepared model regulations and COB rules for States' use on an advisory or voluntary basis. The Work Group discovered late in the development of the COB rules that the NAIC had failed to include any reference to the primacy of Federal law with respect to the order of payments when Medicare was a payer. Due to the Work Group's efforts, this oversight has since been corrected.

On-site visits were made to several plans in order to better understand the environment in which MSP/COB issues surface and to gain first hand knowledge of how the existing provisions are applied by HMOs. Risk-based plans were selected for visits on the basis of in-house documentation which indicated the presence or absence of reported working aged enrollment and where plans indicated that they were pursuing third party recoveries for health care provided or arranged for Medicare enrollees.

Early findings of the Work Group resulted in the preparation of legislative proposals and modification of the COB section of the HMO/CMP manual. These activities will continue until the Work Group has completed its objectives and its final report is released.

Health Care Prepayment Plan Work Group

A HCFA-wide work group convened in June 1990 to evaluate the effectiveness of the health care prepayment plan (HCPP) option in terms of providing coordination of care, beneficiary protections, quality of care, and program cost-efficiency. HCPPs have agree-

ments with HCFA under section 1833 of the Social Security Act. The work group is developing several proposals to make HCPPs conform to many of the section 1876 cost- and risk-based contractor requirements.

While HCPP enrollees now account for one-third of Medicare beneficiary enrollment in HCFA's coordinated care options, HCFA does not have the same statutory and regulatory authority to impose cost-containment and beneficiary protections as it does for risk- and cost-based contracts under section 1876. In addition, HCPPs are becoming an increasingly popular alternative to section 1876 contracting due, in part, to advantages they provide for organizations. In recent years, several risk and cost-based plans have switched to HCPP agreements expressly to avoid the section 1876 requirements that are intended to protect Medicare beneficiaries and also because of dissatisfaction with the payment methodology for risk contracts. Since 1988, 23 section 1876 plans have converted to HCPPs. The work group explored ways to eliminate the gaps in beneficiary protections as currently permitted under HCPP arrangements, and to place a ceiling on cost reimbursement to HCPPs in order to protect the Medicare trust funds.

Unlike section 1876 contracts, HCFA currently cannot refuse to grant an HCPP agreement to an organization on the basis that it has only Medicare enrollment, that it does not meet fiscal soundness and insolvency requirements, and/or that it has no internal quality assurance program. As a consequence, neither HCFA nor the Medicare beneficiary is protected from organizations which have no Medicare or commercial (non-Medicare) experience, which offers no assurance of financial viability, and which operates with no defined and enforced standards of quality of care.

Another important section 1876 requirement that currently does not protect HCPP enrollees is the prohibition against expelling or refusing to enroll or re-enroll someone due to health status. In addition, HCPPs are not subject to the stringent review of marketing materials that section 1876 contractors currently undergo. Review of marketing materials is necessary to assure that Medicare beneficiaries are being told the correct premium charged by the plan and given the correct information about the benefits they are due. Without review of marketing materials, HCFA has no proof that the premium reported to HCFA by the HCPP is the same premium being charged to the beneficiaries or that the benefits being reported to HCFA for reimbursement match the benefits being advertised to the beneficiaries.

Further, the Work Group saw the need to impose a limit on reimbursements to HCPPs in order to assure that HCFA is a prudent purchaser of services. Since HCFA pays the HCPP administrative costs per enrollee, and because the enrollee may not be offered all Medicare-covered services through the HCPP, administrative costs may be paid to the HCPP for enrollees who receive all of their care outside of the HCPP. In addition, HCFA reimburses the HCPP based on a reasonable cost basis (this system is perceived by some to be a more costly reimbursement method), while traditional Medicare fee-for-service is reimbursed on a reasonable charge or fee schedule basis.

In summary, the Work Group identified a number of the critical issues associated with HCPPs and, in response, has been developing a series of proposals to address the problem areas. Specifically, the Work Group plans to craft proposals which make HCPPs conform more closely to section 1876 requirements. For at the present time, section 1833 imposes no organizational requirements on health care prepayment plans (HCPPs) other than that they be prepayment health care organizations serving enrolled members. The absence of such requirements insulates HCPPs from a number of legislative and regulatory safeguards that would otherwise protect the Medicare program and its beneficiaries.

Chapter IV

Efficient Operation of Medicare

Introduction

Medicare contractors fulfill the Federal government's responsibility of paying Medicare beneficiaries and providers of service in a timely, accurate, and fiscally responsible manner. Fiscal intermediaries (FIs) pay providers of services under Medicare Hospital Insurance (Part A), primarily for hospital inpatient activities. Their responsibilities encompass making and accounting for Medicare benefit payments, auditing the financial records of providers, making final settlement of cost reports, recovering any Medicare overpayments, and safeguarding the Medicare Trust Funds against payment for services that are not medically necessary. Carriers adjudicate claims and make payments to beneficiaries and providers of service under Medicare Supplementary Medical Insurance (Part B), primarily for physician services. Their responsibilities include receiving and accounting for Medicare benefit claims, accounting for payments made directly to and/or on behalf of eligible Medicare beneficiaries, determining Medicare's payment amounts for medically necessary covered services, and computing and recovering overpayments in cases of erroneous payment. They also implement the participating physician program, establish methods to identify utilization patterns which deviate from medically accepted norms and report such deviations to the appropriate professional groups.

Distribution of Medicare Claims

Intermediaries received 83.6 million claims in FY 1990, an 8.7 percent increase above the FY 1989 level. Outpatient services accounted for 66 percent and inpatient hospital services for 15 percent of the claims. Home health agency and skilled nursing facility claims accounted for 6.9 percent and 2 percent, respectively. The remaining 10.1 percent were claims submitted for ancillary and other miscellaneous services payable under Part B. The unit cost to process these claims was $1.71. Carriers received 457.4 million claims during the fiscal year, or 10.1 percent more than during FY 1989. The unit cost to process all claims filed with carriers was $1.17.

During FY 1990, approximately 61.8 million of the claims filed with intermediaries and approximately 170.2 million of those filed with carriers were filed electronically. The cost of processing the electronic media claims (EMCs) was about $116 million less than what it would have cost to handle the same number of paper claims.

Claims Processing Timeliness (CPT)

Congress established new policies in section 9311(b) and (c) of the Omnibus Budget Reconciliation Act of 1986 (OBRA 86), which amended sections 1816(c)(2) and 1842(c)(2) of the Social Security Act, for the timely payment of Medicare claims. Both FIs and carriers were required as of the beginning of the fiscal year to pay at least 95 percent of all "clean" Medicare claims within 24 days. They were required to pay 95 percent of all claims within 60 days and 99 percent of all claims within 90 days. Claims submitted by physicians who signed agreements to participate in Medicare were required to be paid within 17 days.

By the end of the fiscal year, FIs and carriers had achieved considerable success in complying with the claims processing requirements. All FIs met the various deadlines for the payment of claims. All except three of the 48 carriers paid all clean claims submitted by

participating physician within 17 days, and at least 95 percent of all other clean claims within 24 days. One carrier each failed to meet the 60-day and 90-day payment deadline standards.

Appeal Rights and Activity

Medicare claimants who disagree with the decisions made on their claims have a right to appeal. After denial of a Part A claim, the claimant can request a reconsideration by the intermediary. If the claim is again denied, the claimant may request a hearing and subsequent review before an administrative law judge (ALJ) and the Appeals Council, respectively, within the Social Security Administration. During FY 1990, there were 28,725 reconsideration requests, a 28 percent decrease from the number of reconsideration requests in FY 1989.

For a denied Part B claim, a claimant has the right to a carrier review, a carrier hearing, and, for claims for services on or after January 1, 1987, a hearing before an ALJ, subject to subsequent review by the Appeals Council. In FY 1990, carriers received 7.4 million review requests, an increase of 9 percent over the FY 1989 level. Of those reviewed, 61 percent resulted in reversals. Carrier hearings during the fiscal year numbered 106,534, an increase of 48 percent over the FY 1989 level. Forty percent of the carrier hearings resulted in reversals.

Common Working File

The CWF is a decentralized Medicare claims validation and benefit authorization process. The fundamental objective is to simplify, speed, and improve Medicare claims processing. Nine host sites maintain beneficiary files containing complete entitlement, utilization and history data. All Part A and Part B claims are processed against this single file. Enhanced protection for the Medicare Trust Funds is achieved, in part, through prepayment Part A and B history reviews, expansion of the base to check for duplicate claims, immediate Medicare secondary payer status updates, and reductions in adjustment processing. This translates into fewer overpayment recovery actions. In FY 1990, all nine CWF host sites were in operation, and eight satellites were on line.

Payment Safeguards

In addition to processing payment claims for providers of service and Medicare beneficiaries, contractors perform other vital functions. These include conducting medical reviews of claims to ascertain whether services are medically necessary and constitute an appropriate level of care, auditing Medicare cost reports of providers, and assuring that under certain circumstances, Medicare is the secondary payer if the health care services rendered a Medicare beneficiary are covered by another insurer. These payment safeguards accounted for savings of more than $5 billion for FY 1990 as follows:

Medical Review/ Utilization Review	$ 1.1 billion
Medicare Secondary Payer	$ 2.56 billion
Audit	$ 1.6 billion

Carrier Medical Review

Ensuring that Medicare payment is made only for reasonable and necessary physician services is the responsibility of the Medicare carriers. Carriers execute this responsibility through a blend of prepayment reviews of individual services and postpayment review of utilization patterns of physician and supplier services.

The medical policy that serves as the basis for the review of screened claims is developed by the carrier medical director, who is a physician, in consultation with the State medical society and other specialty organizations. The policy, which includes information

on appropriate documentation, is communicated to physicians through newsletters prior to its use in the review of claims. Medical reviews have been cost-effective, with FY 1990 program savings of approximately $9 for each administrative dollar expended. FY 1990 saw an increase in the number and quality of local medical review policies developed by the carriers. Two national conferences for carrier medical directors were held by HCFA during the fiscal year. They provided the medical directors with the opportunity to hear clinical presentations, interact with each other, and discuss common policy issues. In addition, each of HCFA's regional offices held at least one regional conference for medical directors. The conferences have contributed to increased uniformity in local medical preview policies nationwide.

Medicare Secondary Payer (MSP) Program

Another effective element of the multifaceted campaign to protect the fiscal integrity of the Medicare Trust Funds is the Medicare secondary payer program. The program, which costs $65.4 million to administer, produced more than $2.5 billion in savings in FY 1990 for a benefit-cost ratio of 38:1. Under the program, HCFA seeks to avoid making primary payments when another party bears primary responsibility for the cost of services furnished to a beneficiary, and seeks repayment of mistaken primary payments made in situations where a third party payer should have made primary payment. In FY 1990, legal action was in progress against three insurance companies for alleged violations of MSP requirements pertaining to employer health benefit plans. Defendants in the suits are Blue Cross Blue Shield of Michigan, Provident Life and Accident, and the Travelers Insurance Companies. Decisions handed down during the fiscal year in the Provident and Blue Cross cases held that Medicare can recover mistaken payments except when the defendant acted solely to provide administrative services.

Another legal action challenging HCFA's policy of requiring hospitals to bill Medicare first in MSP situations was pending at the close of the fiscal year. In a suit brought by the American Hospital Association, the court overturned HCFA policy and permitted hospitals to bill liability insurers and file liens when liability insurers could be expected to pay promptly.

The Blue Cross Blue Shield Association and the Health Insurance Association of America filed a suit in FY 1990 challenging HCFA regulations that became effective November 13, 1989, clarifying and explaining more precisely HCFA policies in MSP situations. This case, too, is pending.

Provider Overpayments

HCFA operates and maintains automated systems that gather information on the amounts and causes of overpayments to providers, on the recoupment of overpayments, and the time associated with the recovery of overpayments. These systems utilize a nationwide telecommunications network linking HCFA's central office with its regional offices and contractors.
The following figures reflect the activity in collecting overpyament made to Medicare providers under Medicare Part A and Part B:

PART A

Starting balance	$399 million
new overpayments	$2.259 billion
collected	$2.333 billion
ending balance	$325 million

PART B

Starting balance	$43.2 million
new overpayements	$107.5 million
collected	$106.5 million
ending balance	$44.2 million

Part A Quality Assurance Reviews

Part A quality assurance reviews (QAR) were employed by HCFA throughout the fiscal year to examine how accurately 10 fiscal intermediaries processed prospective payment system (PPS) bills for inpatient care covered by Medicare. The review detected and corrected errors that would have resulted in an estimated $58 million in mispayments nationally based on the error rates at the intermediaries reviewed.

HCFA continued its program to validate key data on the Provider Specific File, which is critical in calculating the amount of the PPS reimbursement to institutional providers. This enhanced oversight resulted in an increase in the accountability for the accuracy of data developed by Medicare intermediaries as well as more effective monitoring by HCFA of the validity of the data.

Part B Quality Assurnace Activities

HCFA also maintained Part B quality assurance programs at all carrier sites during the fiscal year. An analysis of the processing of Medicare claims indicated that the national payment error rate rose slightly during the fiscal year to 1.26 percent from 1.2 percent in FY 1989. Twenty-three carrier sites had a decrease and 26 had an increase in their error rate from the previous reporting period.

HCFA pursued several activities during the year to further improve carrier quality assurance, including the development of a more efficient means for carriers, and HCFA central and regional office staffs to access the expanded quality assurance data base. When implemented in October 1990, this change will facilitate corrective action analyses and resolution of claims processing deficiencies.

A computerized editing program was also introduced during the fiscal year to measure the accuracy of the annual reasonable charge update. The program was tested twice during FY 1990, first when the reasonable charge screens were updated, and a second time six months later to analyze subsequent changes in the reasonable charge screens. The edits detected more than $4.1 million potential mispayments for which immediate corrective action was taken.

Operational Reviews

The Physician Global Service Package studies, begun in 1987, involved defining and/or bundling a standard package of services (pre-, intra-, and post-operative) for a typical Medicare beneficiary for five surgeries. Each study involved conducting extensive literature searches on the surgical topic, performing in-depth analyses of Part B beneficiary filed data, developing a preliminary global package (Phase I); presenting the global package to a panel of expert physicians and compiling their comments and recommendations (Phase II); computing the average and the maximum payment amount for each surgery (pricing out the package) and determining the extent of variance of the package with current carrier policies (Phase III). Two surgeries (cataract extraction and coronary artery bypass graft (CABG)) were planned as a three-phase study, and because of staffing constraints and competing priorities, three surgeries (transurethal resection prostatectomies (TURP), major hip reconstruction, pacemaker), were planned as a two-phase study. The following is a brief summary of the work that was in progress in FY 1990:

Cataract: Using information obtained from previous studies of the cataract procedure, HCFA identified the typical operative procedures for a cataract operation, and calculated the amount each Medicare carrier paid for those procedures, or "package of services." It was found that there were wide variations in the fee paid by carriers for this package of services which did not appear to be related to cost-of-practice variations or other pricing factors. Accordingly, HCFA's Bureau of

Policy Development was assigned the task of developing proposals for reducing the fee variations should new overpriced-procedures legislation be considered by Congress.

CABG: A study of physicians' billings for this type of surgery revealed that some primary surgeons billed not only for the CABG surgery, but also on a fragmentation basis for other services related to the surgery such as hospital visits and the interpretation of tests. To a lesser degree, it was additionally found that some assistant surgeons and anesthesiologists billed not only for their respective role in the surgery but also for certain intraoperative procedures such as wound closure and placement of monitoring lines.

TURP: Detailed procedure data for a sample of beneficiaries who received a TURP in 1986 was obtained and reviewed. These data showed all the providers billed the Medicare program for a period of six months before and after the procedure. Procedures which previously were not related to a TURP were first removed from the data. Next, the relative frequency of occurrence for all remaining procedures, the physician specialty doing the billing and the time period before and after the procedure was established. A urology physician panel was then convened to examine these data and to interpret for HCFA what procedures are provided to a typical TURP patient. The panel identified the services provided to a typical TURP patient.

Hip Reconstruction: This was a complex and intensive study. An analysis of payment data on 23 major surgeries for incorporation into two global fee packages was completed—one package for surgeries generally performed as initial procedures (first surgery) and another package for secondary procedures (second surgery on the same hip). The packages focused on the services provided by the primary surgeon, including related pre/intra/post-operative services. HCFA found that post-operative care for hip reconstruction surgery last longer than that other types of surgery.

Pacemaker: This study established one global fee package for pacemaker surgery. HCFA's physician panel advised the Agency that most pacemaker patients have a history of cardiac problems and pacemakers are implanted in only 20 percent of patients as a "cure all" procedure. Moreover, the panel reported, the primary care physician performs very few of the pre/post-operative services surrounding the surgical procedures. Therefore, prior to establishing the global fee package of services, all factors (e.g., medical necessity procedures, specialist performing the surgery) were taken into consideration. HCFA's recommendations, for the most part, were in line with the Physician Payment Review Commission's global model of services.

Carrier Prepayment Medical Review Screens

In a study of carrier prepayment medical review screens, HCFA analyzed the cost-effectiveness of nationally mandated and local screens which could be considered for national implementation. It also verified the accuracy of information submitted by the carriers in their quarterly medical review reports to the Agency. Study findings included recommendations for improving the effectiveness of mandated screens for physician hospital visits, comprehensive office visits and concurrent care, and for identifying local screens that might effectively be used as national screens. Local screens were recommended for seatlift chairs, automated multichannel laboratory tests, extended office visits, cerebrovascular arterial studies, eye examinations, chest X-rays, consultations, extended hospital visits, and second assistants at surgery. Action on the recommendations was scheduled for early in the next fiscal year.

Contractor Performance Evaluation Program

HCFA'S Contractor Performance Evaluation Program (CPEP) was used to rate the performance of Medicare contractors. For example, in FY 1990, 21 of the 60 total standards for FIs and 21 of the 75 total standards for carriers were designed to evaluate contractor performance with respect to payment safeguards. Selected standards included Medicare secondary payer goals, cost-effective medical review and audit programs, detection of fraud and abuse cases, limiting the incidence of provider overpayment, and ensuring that no payments are made to excluded, terminated or suspended providers or physicians. Fifty-two of 54 intermediaries and 38 of 48 carriers met the CPEP standards. The 10 carriers failing to meet the standards were required by HCFA to establish corrective action plans to remedy their performance deficiencies.

HCFA utilizes the Uniform Contractor Evaluation Program (UNICEP) as the primary instrument to evaluate the quality of Medicare contractor performance in the area of auditing and setting Medicare cost reports (hospitals, home health agencies, skilled nursing facilities and chain organizations). The UNICEP produces a score that is used in the CPEP.

Replacement Contractors

At the beginning of FY 1990, Iowa-South Dakota Health Services Corporation and New Mexico Blue Cross and Blue Shield assumed the Part A bill workload of Blue Cross of Western Iowa and South Dakota and Colorado Blue Cross, respectively. Equicor-Wyoming withdrew as a Medicare carrier in mid-year and its workload was assumed by Blue Cross Blue Shield of North Dakota. The contracts held by Louisiana Blue Cross and Washington Physicians Service also were not renewed at the end of the fiscal year. Their workloads were assigned to Mississippi Blue Cross and King County Medical Blue Shield, respectively.

Beneficiary Inquiry Workloads at Carriers and Intermediaries

During FY 1990, Medicare intermediaries handled 1,960,949 beneficiary inquiries (1,608,737 telephone, 312,355 written, and 39,857 walk-in), and 2,032,281 inquiries from providers (1,273,803 telephone, 756,800 written, and 1,678 walk-in). The number of beneficiary inquiries increased 8.2 percent from the FY 1989 level.

Beneficiary inquiries to Medicare carriers increased by 8.2 percent to 20,418,189 queries (18,325,176 telephone, 1,731,638 written, and 361,375 walk-in). Carriers also handled 9,197,322 provider inquiries (6,015,002 telephone, 3,162,117 written, and 20,203 walk-in). This represented an 8.5 percent increase in provider inquiries over the previous 12 months. Beneficiary and provider inquiries totaled 29,615,511.

Medicare carriers were reminded of the importance of the requirement that they provide beneficiaries with satisfactory local and toll-free telephone service. Carriers must meet busy signal and call acknowledgement standards for telephone service, and are required to electronically monitor telephone service performance. Monthly performance reports are required and if a carrier does not meet minimum standards, corrective action is taken by the appropriate HCFA regional office. During the fiscal year, carriers maintained an average 7.4 percent all-trunks-busy (ATB) level of service in comparison with a standard of not more than 20 percent ATB.

Participating Physician Program

The Deficit Reduction Act of 1984 (DEFRA 84) created the participating physician program under which physicians and suppliers may make a voluntary choice each year to accept assignment on all Medicare claims for the following year. Those who accept assignment agree to accept Medicare approved amounts as payment in full for their

services regardless of the actual charges. On assigned claims, they bill the beneficiary only for applicable deductible and coinsurance amounts. During FY 1990, 44.1 percent of the physicians (329,008) and 22.6 percent of the suppliers (27,445) signed Medicare participation agreements.

The Omnibus Budget Reconciliation Act of 1987 (OBRA 87) provided for an additional payment of 5 percent for physician services rendered in rural health manpower shortage areas effective January 1989. The payments, which are made on a quarterly basis, are intended to provide an incentive for physicians to serve in medically underserved areas. Medicare carriers disbursed a total of $4 million in incentive payments for eligible physician services rendered in 1990.

Development of Physician Registry

Progress was made during the fiscal year toward implementing section 9202(g) of Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA 85), which requires HCFA to develop a system of unique physician identifiers. The unique physician identification numbers (UPINs) are to be used in claims payment to facilitate tracking of program expenditures and physician practice patterns. Under the system, Medicare carriers are required to submit physician records to the registry and the registry is to match the records against the American Medical Association's supplied records to corroborate the identity of medical doctors before assigning a UPIN. Numbers have been assigned to more than 500,000 medical doctors, doctors of osteopathy, doctors of dental medicine, dental surgeons, podiatrists, optometrists and chiropractors. Procedures have been added to identify physicians who are sanctioned by the Office of the Inspector General and deceased physicians and HCFA is planning to assign numbers to resident physicians and interns.

OBRA Mandates Physician Payment Reforms

A significant number of provisions affecting physician payments were enacted as part of Omnibus Budget Reconciliation Act of 1989 (OBRA 89), which was signed into law December 19, 1989. In compliance with provisions of the law, HCFA accomplished the following, through the use of numerous instructions and issuances:

- Prepared all materials used by Medicare carriers to inform physicians and suppliers of the Medicare payment screens and amounts which went into effect in 1990. Additionally, physicians and suppliers were informed of the new requirement that they submit unassigned claims to Medicare on behalf of beneficiaries. That requirement, enacted in OBRA 89, went into effect for services furnished on or after September 1, 1990.
- Implemented payment reductions in approximately 250 procedures identified as "overvalued" in OBRA 89. These reductions were implemented through the use of a detailed statutory formula. This, in effect, was moving the usual, customary and reasonable (UCR) system of payments, for the particular services, toward the new physician fee schedule which OBRA 89 established for 1992 and thereafter.
- Implemented a transition fee schedule for physicians who practiced primarily nuclear medicine. This permitted those physicians—for a period of two years—i.e., until the 1992 fee schedule is to be implemented—to be paid based on a combination of the radiology fee schedule and the old prevailing charge amounts, rather than entirely on the radiology fee schedule.
- For certain services, implemented a special payment limitation which capped the Medicare allowance at the prevailing charge amount of the specialty which most

frequently performed the service. This was referred to as the designated specialty reduction.

- For primary care services, the floors or minimum prevailing charges that could be used for those services were computed. This implemented a statutory policy intended to increase primary care payment in particularly low-paying areas.
- With the objective of moving the 1990 UCR payment amounts toward the allowances that would later be in effect under the physician fee schedule, a 4 percent reduction was implemented in radiology fee schedule services (for other than portable x-ray providers), a zero percent increase in other radiology services and in anesthesia services, a 4.2 percent increase in primary care services and a 2 percent increase in other physicians' services.
- Established payment rules for nurse practitioner services, newly-covered under OBRA 89.

Restriction of Payment to Referring Laboratory

Prior to January 1, 1990, independent laboratories were permitted to bill for all tests performed for patients even if some (but not all) of the tests were referred to another laboratory.HCFA issued reimbursement guidelines that implemented the provisions of section 6111 of the OBRA 89. That section provides that payment for clinical diagnostic laboratory tests to a referring laboratory may be made only if (1) the referring laboratory is located in, or is part of, a rural hospital; (2) the referring laboratory is wholly owned by the laboratory performing the test, the performing laboratory is wholly owned by the referring laboratory, or both the referring laboratory and the performing laboratory are wholly owned by a third entity; or (3) not more than 30 percent of the tests for which the referring laboratory submits bills or requests payments within a year are performed by another laboratory. This section applies to clinical laboratory tests furnished on or after January 1, 1990.

Durable Medical Equipment (DME)

Medicare utilizes fee schedules under Part B (and under Medicare Part A for an HHA) to pay for covered DME, prosthetics, and orthotics. In general, payment is limited to the lower of the actual charge for the item or the fee schedule amount. Items are classified into six groups for purposes of determining the fee schedules and making payments. Dependent upon the class of an item, payment may be made on a purchase or rental basis.

To refine the payment amounts, section 6112 of OBRA 89 requires a cap of 15 months on rental payments for parenteral and enteral pumps and establishes coverage of reasonable maintenance and servicing fees to be paid after the period of rental payments has expired, effective April 1, 1990. Section 6112 also reduces payment amounts for seatlift chairs and transcutaneous electrical nerve stimulators by 15 percent for items furnished on or after April 1, 1990.

Medicare Volume Performance Standard

The physician payment reform provisions of the OBRA 89 contained three major elements: replacement of the reasonable charge payment system with a fee schedule; establishment of Medicare Volume Performance Standard (MVPS) rates of increase for physician service expenditures; and replacement of the maximum allowable actual charge with a new limiting charge to constrain the amounts of billing in excess of the Medicare allowance. The first of these new provisions to take effect was the MVPS. Congress enacted the MVPS to address the problem of unacceptably high annual rates of increase in Medicare expenditures for physician services. Past efforts, such as the physician fee freeze in effect in 1984 to 1986, achieved only limited success in slowing the rate of increase because both the

volume and intensity of physician services continued to increase. Using performance standard rates of increase was intended to involve physicians in the effort to slow expenditure growth by encouraging them to evaluate their services and eliminate those that are inappropriate or ineffective.

Under section 1848(f) of the Social Security Act, as added by OBRA 89, the first MVPS performance standard was to be established for FY 1990. HCFA prepared the first MVPS notice establishing the performance standard and it published it in the December 29, 1989, issue of the Federal Register. The computation formula for the performance standard rate-of-increase was specified in the law at 1848(f)(1)(D). The process for subsequent years is different, with an April recommendation by the Secretary, an opportunity for the Congress to react to the recommendation, and a "default" formula for computing a standard to be published by October if the Congress chose not to act. Following the statutory guidelines, HCFA computed an FY 1990 performance standard rate of increase of 9.1 percent by summing the following components less 0.5 percent:

- An estimate of the weighted average percentage increases in reasonable charges for physician services for portions of calendar years 1989 and 1990 contained in FY 1990.
- An estimate of the percentage increases or decreases in the average number of Part B enrollees from FY 1989 to FY 1990.
- An estimate of the average annual percentage growth in volume and intensity of physician services for FY 1985 through FY 1989.
- An estimate of the percentage increase or decrease in expenditures for physician services that will result from changes in law or regulations in FY 1990 as compared with expenditures for physician services in FY 1989.

The performance standard rate of increase established for FY 1990 was not a limit on expenditures. It was a standard against which actual expenditure growth would be measured. If expenditures were greater than or less than the standard, the difference could be taken into account in computing future payment updates. In other words, if expenditures exceeded the standard, future updates could be adjusted downward, while expenditures less than the standard could result in higher update amounts.

Model Fee Schedule

The physician fee schedule was the centerpiece of physician payment reform. Under the provisions of OBRA 89 it was to begin taking effect on January 1, 1991. As a first step, OBRA 89 required HHS to prepare a "model" fee schedule, using the methodology prescribed for the actual fee schedule, to be submitted to the Congress and made available to the public by September 1, 1990. The model fee schedule was to include "as many services as the Secretary concludes can be assigned valid relative values".

During FY 1990, HCFA developed the model fee schedule and it was published in the Federal Register on September 4, 1990 (55 FR 36178). Its narrative portions described the statutory requirements, listed and explained the technical and policy issues left to the Secretary's discretion, and described steps that had been taken and that were planned in order to resolve the outstanding issues. Preferred options were identified in some cases; in other cases, options were discussed without identification of a preferred approach. The model fee schedule described physicians' services to be included in the fee schedule, the formula for computing payment amounts, sources of the relative value units for procedures, updating the relative value units, the development of a geographic adjustment factor, and calculation of a budget neutral conversion factor. It also covered issues

relating to defining a unit of service, including pending changes in medical visit coding, the scope of the global surgical package, and treatment of new services. Also discussed were adjustments to the fee schedule payments based on the site of service, payment modifiers, and professional and technical component services.

The addenda to the model fee schedule notice provided preliminary estimates of the relative values associated with the approximately 1,400 services studied as part of the Harvard Phase I study as well as preliminary values for geographic practice cost indices for all existing Medicare localities. Using these tables, readers could compute very preliminary estimates of payment amounts for particular services in particular localities under the fee schedule. The model fee schedule notice provided for a 60-day comment period; comments received within that time would be considered in the development of the physician fee schedule proposed rule.

Medicare Implements Home Dialysis Payment Limit

Medicare implemented section 6203 of OBRA 89 which provides for a limit on the payments for home dialysis equipment, supplies and support services beginning February 1, 1990. This limit is equal to the median composite rate paid to hospital-based dialysis facilities for similar items and services, except in the case of one form of home dialysis, continuous cycling peritoneal dialysis, which has a limit equal to 130 percent of the median. The home dialysis supplier is required to accept assignment of this benefit. In addition to the payment limit, this provision also required that the home dialysis supplier have a written agreement with a Medicare approved dialysis facility under which the facility agrees to provide all of the necessary home dialysis support services and emergency dialysis services required by the patient.

Rates for Ambulatory Surgical Centers

During the fiscal year, HCFA updated the payment rate methodology and payment rates for ambulatory surgical center (ASC) facility services furnished in connection with covered procedures under Medicare Part B, §1833(i)(2)(A) of the Social Security Act. Using audited survey data, HCFA refined the methodology used to determine ASC payment rates, and expanded from four to eight the number of payment groups into which Medicare covered procedures are classified. ASC payments for geographical wage variations were also standardized by adopting the October 1, 1989, hospital wage index. Medicare payments to ambulatory surgical centers (ASCs) increased on average approximately 13 percent during FY 1990.

As required by §4063(b) of the OBRA 87, HCFA defined an intraocular lens (IOL) inserted during or subsequent to cataract extraction as an ASC facility service, and added onto the payment rates for IOL insertion procedures a $200 IOL allowance.

Medicare Secondary Payer Program Change

Final regulations (BPD-302-F) pertaining to Medicare as secondary payer (MSP) and certain nonmedical exclusions from Medicare coverage were published in the October 11, 1989, issue of the Federal Register. In addition to updating and revising MSP and coverage policies, the final rule reflected statutory changes which strengthened and expanded the scope of the MSP program. The MSP program, which requires certain other medical benefits to pay before Medicare, saves the Medicare Trust Funds hundreds of millions of dollars each year.

Medicare Heart Transplant Centers

Fifteen more hospitals meeting special criteria established by HCFA were approved by the Agency during the fiscal year as Medi-

care heart transplant centers. The designations were made with the advice and recommendations of recognized experts outside the Federal government. The hospitals approved were: St. Joseph's Hospital, Atlanta, GA; Vanderbilt University Medical Center, Nashville, TN; Ohio State University Hospitals, Columbus, OH; Abbott-Northwestern Hospital, Minneapolis, MN; University of Michigan, Ann Arbor, MI; Ochsner Foundation Hospital, New Orleans, LA; Shands (University of Florida) Hospital, Gainesville, FL; Lutheran Hospital of Ft. Wayne, Ft. Wayne, IN; Presbyterian Hospital, Albuquerque, NM; St. Luke's Medical Center, Milwaukee, WI; Indiana University Hospitals, Indianapolis, IN; St. Luke's Hospital of Kansas City, Kansas City, MO; Baylor University Medical Center, Dallas, TX; Emory University Hospital, Atlanta, GA; and Humana Hospital of San Antonio, San Antonio, TX. By the end of FY 1990 there were a total of 46 Medicare-approved heart transplant centers.

Medicare Payments for Epoietin Rise

By the end of September 1990, 51 intermediaries reported billings for Epoietin (EPO) from 1,721 of the 1,947 dialysis facilities serving Medicare beneficiaries. The average hematocrit continued to rise, reaching 28.7 percent by the end of the fiscal year. The target hematocrit for renal patients is from 30 to 35 percent. The average dose per administration increased during the fiscal year from 2,000 units to 2,709 units.

Chapter V

Research, Demonstrations, and Evaluations

Introduction

For a substantial period of time, the costs of health care services have been outpacing the rate of inflation in the general economy. This means that not only has the absolute number of dollars spent on health care increased rapidly, but also the proportion of the GNP related to health care has increased. This trend continues to be a matter of primary concern to HCFA as the leading purchaser of health care in the United States.

Since the establishment of HCFA, the overall purpose of its research and demonstration (R&D) program has been to find ways to moderate or control this inflationary trend and to ensure that every dollar is used effectively in the service of Medicare beneficiaries. HCFA's R&D activities provide knowledge to enable the Administrator, the Secretary, Congress and other interested parties to make informed decisions regarding HCFA programs and policies.

HCFA's existing research, demonstration and evaluation activities include projects to test new reimbursement, coverage, eligibility and program management approaches, as well as research and evaluation studies of the impact of HCFA programs on health care costs, program expenditures, beneficiary access to quality health care services and the economics of the health care industry. HCFA is extensively involved in the creation of new and improved data sets to support these ongoing R&D activities. These projects result in knowledge about the basic structure, incentives, costs and effects of HCFA programs and policies and make it possible to refine existing policies, simulate or test various program changes on a trial basis, and develop innovative financing and delivery systems.

In addition to its intramural projects, HCFA spent over $49 million for grants and contracts to conduct research, demonstration, and evaluation projects during the fiscal year. Of this amount, $33.6 million went to the approximately 300 studies that continued into FY 1990 from previous years. An additional $15.5 million went to fund 238 new projects, including $9.4 million awarded to 211 hospitals under the Rural Health Care Transition Grant Program.

The seven program areas addressed were:
(1) Quality of Care
(2) Physician and Ambulatory Care Payment Systems
(3) Capitated Payment Systems
(4) Hospital Payment
(5) Program Efficiencies, Analyses and Refinements
(6) Health Care Prevention and Access
(7) Subacute and Long-Term Care.

More specific information on individual projects can be found in the FY 1990 edition of Status Report: Research and Demonstrations in Health Care Financing.

Quality of Care ($6.4 million)

There are many relevant issues within the quality of care area. HCFA has a continuing interest in quality issues as they relate to:
(1) the impact of payment mechanisms, such as the prospective payment system, on quality of care;
(2) the impact of severity of illness on health care outcomes;
(3) the effectiveness of alternative medical interventions on the health of Medicare beneficiaries; *and*
(4) access to and quality of services in subacute care settings, such as home health and skilled nursing care.

Program changes have the potential to impact on the quality of care provided to program beneficiaries. In order to assess the impact of such changes, as well as to ensure continued access by program beneficiaries to quality care, it is essential that valid quality of care measures for different treatment settings be developed. Twenty-five studies from previous years continued into FY 1990. Among these were:

Hospital, Market, and Peer Review Organization Factors Affecting Unnecessary Utilization and Quality of Care (Abt Associates, Inc.). This Congressionally mandated study examines the interrelationship among PROs, the PPS, and utilization and quality of care problems.

Strategies for Assessing and Assuring Quality of Care in the Medicare Program (National Academy of Sciences). This is a 2-year Congressionally mandated study (P.L. 99-509) to design a strategy for assessing and ensuring the quality of care in the Medicare program. Its main purpose is to develop, within a committee of experts, a recommended strategy for quality review and assurance for Medicare beneficiaries.

Impact of the Diagnosis-Related-Group-Based Prospective Payment System on Quality of Care for Hospitalized Medicare Patients (The RAND Corporation). This study evaluates the impact of the PPS on quality of care. The effectiveness of medical care treatment is evaluated by relating quality scores to mortality, readmission rates, and other outcome variables.

Study of Home Health Care Quality and Cost Under Capitated and Fee-For-Service Payment Systems (Center for Health Policy Research). This project is designed to compare the quality and cost of home health care provided under capitated and noncapitated payment systems for two groups of Medicare beneficiaries: clients admitted to home health care following a hospitalization, and those who have not been in a hospital for at least 30 days prior to the initiation of home care.

Development of Outcome-Based Quality Measures for Home Health Services (Center for Health Policy Research). The purpose of this ongoing contract is to develop and test outcome-based measures or indicators of quality for Medicare home health services. The measures are to be reliable and valid for use in monitoring and comparing quality of home health care across agencies, recognizing possible confounding factors such as case mix.

The Use of Medicaid Reimbursement Data in the Nursing Home Quality Assurance Process (Center for Health Systems Research and Analysis). This project assesses the feasibility of using Medicaid reimbursement data to target facilities and residents in the nursing home quality assurance survey process. These data appear to hold considerable promise in helping target facilities for more intensive review, identifying specific areas of deficient care, and identifying individual residents for more detailed review.

Medicaid Quality of Care Study (SysteMetrics Inc./McGraw Hill). This Congressionally mandated study (P.L. 99-509) examines the appropriateness, necessity, and effectiveness of selected medical treatments and surgical procedures for Medicaid patients.

Outcome Measures for Assessment of Hospital Care (University of Minnesota Research Center). This ongoing project explores the usefulness of outcome measures other than mortality in assessing the effectiveness of hospital care.

Interpreting Hospital Mortality Data: How Much Can Patient Severity and Quality of Care Explain? (The RAND Policy Research Center). This project examines the Medicare Mortality Predictor System, with a goal of enhancing and refining its capabilities and usefulness.

- Investigate the statistical properties of and develop a theoretically defensible standard error estimator for the MPS rate estimator.
- Develop a Baysian estimator for hospital mortality rates.
- Further investigate the sample design used to estimate the MPS risk-adjustment equations.

Estimate how much of the variance in hospital mortality rates is attributable to variation in severity versus variation in quality of care.

Evaluating Quality of Care for Hospitalized Patients (Brandeis University Research Center). Equation-based severity models will be developed using common clinical information abstracted from charts on hospitalization to predict adverse surgical outcomes such as readmission, common surgical complications (including unplanned return to surgery), and evidence of a post-surgery myocardial infarction. This work will further HCFA's ability to compare the quality of surgical cases using outcomes more sensitive than mortality with adequate severity of illness adjustments.

Psychoactive Drug Use Among Nursing Home Elderly (University of Minnesota Research Center). This study will examine the extent of regular and "as needed" psychoactive drug use among nursing home elderly and the possibility of appropriate and inappropriate use of such drugs in terms of characteristics of nursing home residents and nursing homes.

The new quality of care studies in FY 1990 included:

New York State Quality Assurance System Evaluation (Abt Associates, Inc.). The objectives of the New York State Quality Assurance System (NYQAS) are to link data from the case-mix reimbursement system for use in the quality assurance system and to integrate the quality assurance processes of survey and certification, inspection of care, and utilization review. This evaluation is designed to determine which aspects of NYQAS are effective, which are not, and why. Researchers hope that this information will improve the implementation and monitoring of the multi-State Nursing Home Case-Mix and Quality Demonstrations, the nursing home reform provisions of OBRA 87, and the surveillance of nursing homes in general. The evaluation will employ a variety of qualitative and quantitative methods to assess NYQAS's reliability and validity of problem identification, monitoring, and enforcement, and the impact of NYQAS on the quality of care.

Utility of Medicaid Claims Data for Deriving Nursing Home Quality Indicators (SysteMetrics/McGraw-Hill). The goal of this project is to investigate the usefulness of claims data from Medicaid and Medicare administrative records systems as sources of nursing home patient treatment and outcome measures. The study will involve retrospective analysis of 1987 Medicaid and Medicare claims data from four States: California, Georgia, Michigan, and Tennessee. The innovative element of this study is the identification, using routinely collected claims data, of sentinel health events that are diagnosis codes for which hospitalization represents an adverse patient outcome of nursing home care.

Aftercare Guideline Manual (Mathematica Policy Research, Inc.). The purpose of this project is to develop a manual that can serve as a tool for hospital discharge planners and other health care professionals in formulating patient care plans covering the immediate post-hospitalization period.

Evaluating Quality of Care for Surgical Patients: Using Diagnosis-Related Group and Quality of Care Data for Research on Hip Patients (The RAND Policy Research Center). HCFA is developing a way to use data from the Medicare provider analysis and review (MedPAR) files to study adverse outcomes for eight major surgical procedures, two of which involve the treatment of broken hips.

Medical record abstracts for 2,853 hip fracture patients will be examined and compared with their MedPAR records. The investigators will determine which characteristics present at the time of hospital admission are associated with adverse patient outcomes and the extent to which adverse outcomes are related to poor processes of care.

Clinical Homogeneity of Severity of Illness Measures (Brandeis University Research Center). This project is designed to test whether abstract-based and Uniform Hospital Discharge Data Set-based severity systems define clinically homogeneous patient groups, and, if not, which types of cases are misclassified. Physicians will review patient charts and will classify the degree of severity for each case. Comparisons will be made between the physicians; clinical evaluation of severity and data gathered from the computerized systems.

Physician and Ambulatory Care Payment System ($7.3 million)

HCFA's physician and ambulatory payment research agenda is based on a commitment to better understand the underlying reasons for the rapid growth in Medicare spending for physician and outpatient services and to implement reforms to the current system. The research is intended to support proposals for reform of Medicare physician and ambulatory care payment policies and be responsive to the increasing interest on the part of Congress in developing more rational payment systems.

Forty-three extramural studies in these areas continued into FY 1990 from previous years, including:

Geographic and Temporal Variations in Medicare Physician Expenditures (Center for Health Economics Research). This project addresses a broad range of physician payment issues, including overpriced surgical and anesthesia fees, decomposition of Part B expenditures into price and quality components, effect of competition on price and quantity variation, variation in assignment rates and participation, and incentives provided by Medicare's at-risk payment rates.

A National Study of Resource-Based Relative Value Scales for Physician Services (Harvard School of Public Health). Phase I of this Congressionally mandated study (P.L. 99-272, 99-509, and 100-203) developed a national resource-based relative value scale and presented results for physician services in 18 specialties. Resource-based relative values are hypothesized to be a function of physician work before, during, and after the service, specialty-specific relative practice costs, and specialty-specific relative opportunity costs. The Phase I study showed a large variation in resource requirements both within and among specialties. Phase II extends the study to 15 additional specialties and subspecialties and refines and revises the study methodology. Phase III will further refine the study.

Toward Prospective Payment for Outpatient Department Surgical Services (The Urban Institute). This Congressionally mandated project (P.L. 99-509) will provide information necessary to assist HCFA in designing a PPS for surgical procedures performed on a hospital outpatient basis.

Development of a Prospective Payment System for Hospital-Based Ambulatory Surgery (Brandeis University). This Congressionally mandated project (P.L. 99-509) will provide information needed to assist in the development of a Medicare PPS for hospital outpatient surgery. This project will compare and evaluate the utility of several alternative patient classification systems in classifying outpatient cases by relative resource intensity.

Design and Evaluation of a Prospective Payment System for Ambulatory Care (Health Systems International). This Congressionally mandated project (P.L. 99-509) will develop a patient classification system that

can be used as the basis of payment for an outpatient PPS for Medicare. The payment system must be administratively feasible, implemented with Medicare claims data, and applicable as a basis of payment for facility costs and potentially for physician fees. Another task of the project is to develop a system that can be used for the prospective payment of ambulatory care services in both hospitals and ambulatory surgical centers.

Medicare Cataract Surgery Alternate Payment Demonstration (Abt Associates, Inc.). The objective of the task is to assist HCFA in the design, implementation, and evaluation of a demonstration to assess the feasibility of an all-inclusive negotiated price concept for cataract surgery. The negotiated price, covering physician, facility, and intraocular lens costs for the procedure, would be tested at three sites, but participation by providers and beneficiaries at each site would be strictly voluntary.

Medicare Participating Heart Bypass Center Demonstration (Lewin/ICF). The task objective is to assist HCFA in implementing and evaluating a 3-year demonstration designed to assess the feasibility of a negotiated all-inclusive pricing arrangement for coronary artery bypass graft surgery while maintaining high-quality care.

Physician Preferred Provider Organization Demonstration Sites (Family Health Plan; CAPP CARE, Inc.; HealthLink, Inc.; CareMark, Inc.; Blue Cross and Blue Shield of Arizona). Five preferred provider organizations (PPOs) are participating in this Medicare physician PPO pilot demonstration. These demonstrations will enable HCFA to assess the operational feasibility of the Medicare PPO concept through an analysis of biased selection, beneficiary choice, and the impact of the demonstration on Medicare costs and utilization. Since each site is a unique model, the evaluation will also examine how the sites' features contribute to their individual success.

Determinants of Cost of Care: The Influence of Physician Style Versus Patient Characteristics (University of Minnesota Research Center). Significant variations in the cost of managing patients with the same diagnosis have been documented. This ongoing study will help determine what percent of variance in the cost of care is caused by physicians' unique practice patterns and what percent is caused by differences in patient population characteristics and disease severity.

Medical Visit Coding (The RAND Policy Research Center). The primary objective of this now-completed study was to describe the variation in intensity of medical visits and to evaluate the impact of alternative ways of coding medical visits. The descriptive analysis examined the impact of five factors on variations in the coding of intensity level for medical visits at the local carrier. (The factors were relative prices by carriers across visit codes, billing practices, specialty mix, frequency of visits, and individual physician practice patterns.) In addition, RAND evaluated the potential impact of alternative coding schemes on Medicare payments and physicians, including the measures of time and/or collapsed versions of the current coding system for medical visits.

In FY 1990, HCFA also implemented 28 new physician and ambulatory care payment studies. Among them were:

Physician Reaction to Price Changes (Health Economics Research, Inc.). The response of physicians to price changes is a critical issue, especially as Medicare moves to a fee schedule that redistributes fees among types of services and among areas of the country. It has widely been assumed that physicians react to price reductions in some fashion. The reaction could be manifest with providing a different quantity of the same service or of another service, changing billing practices, or changing practices regarding reporting of services. The researchers will

produce a descriptive analysis of utilization of the overpriced procedures between 1985 and 1989 on a procedure-specific quarterly-pricing locality basis. Researchers will also perform a descriptive analysis of trends in episodes of care. This analysis will identify changes in the provision of overpriced procedure-related services that the physician may alter in response to the price reduction.

Medicaid Fees and Physician Participation (The Urban Institute). The purpose of this project is to:

(1) Collect recent data on Medicaid fee levels;
(2) compare these levels with the present Medicare fees, fees of other private payers, and the Medicare fee schedules enacted by the Omnibus Budget Reconciliation Act of 1989; and
(3) examine the relationship between these fee levels and physician participation in Medicaid.

Beneficiary Use of Services Over Time (Brandeis University Research Center). This project will examine changes in the patterns of Part B spending over time at the individual beneficiary level, including not only users of physician services but nonusers as well. In particular, this project will decompose spending growth into its major components (i.e., user rates, services per user, and price per service) and will compare rates of changes in these components for beneficiaries of varying characteristics. This project will also examine changes in the composition of spending on physician services, such as the extent to which services are being provided in offices and hospital outpatient departments versus other settings.

Analysis of Group-Based Methods for Medicare Fee Schedule Refinement (The RAND Policy Research Center). The objective of this study is to evaluate alternative group-based methods of policy decisionmaking to ascertain the costs and benefits of each as a tool for determining new or revised Medicare fees based on a resource-based relative value scale.

Survey of State Regulation of Physician Office Medical Equipment (Project HOPE Research Center). This project will determine the nature and scope of State regulation of physician office medical equipment other than laboratory equipment. The analysis will cover selected States, some that regulate various types of physician office equipment, others that do not. The analysis will also examine the extensiveness of such regulation, whether equipment is inspected for general health and safety reasons, and whether the equipment is tested for accuracy. The analysis will focus on the types of physician office medical equipment that produce high-volume Medicare tests, including radiology equipment and physiological testing equipment.

Place of Service Payment Differentials (Brandeis University Research Center). This project will be used to analyze patterns of ambulatory surgery and the payment rate differentials between physicians and facilities across three ambulatory settings: physicians' offices; hospital outpatient departments, and freestanding ambulatory surgical centers. The study will describe high-volume ambulatory surgery procedures, calculate percentage distributions of high-volume surgical procedures, develop alternative payment approaches for ambulatory surgical procedures, and estimate the effect of these alternatives on Medicare payments.

Ambulatory Cardiac Monitoring (University of Minnesota Research Center). The primary goals of this project are to develop and pilot test an instrument which collects supplemental data from physician providers to guide HCFA in reimbursing ambulatory cardiac monitoring and to design a large-scale intervention to assess the feasibility of obtaining this information from providers on a routine basis.

Capitated Payment Systems ($2.1 million)

Prior R&D activities involving HMOs determined that alternative coordinated/ managed care delivery systems and alternative risk reimbursement mechanisms are cost-effective and offer Medicare beneficiaries the opportunity for improved benefits over the existing fee-for-service system. Twenty-three studies testing alternative payment methods, including four new studies, were underway in FY 1990 in such areas as outpatient services payment, the Medicare Insured Group (MIG) demonstrations, and State programs for long-term care. Projects tend not to be limited to one segment of the Medicare population or to one aspect of the health care delivery and financing system. Within this area, researchers attempt to identify, test and evaluate cost-effective alternative delivery and/or financing systems that affect multiple segments of the program. Therefore, the agency continued to examine coordinated/managed care delivery systems involving capitated payments for various types of services and those projects that tried to refine or test alternatives to the current methods and bases for payments to capitated systems. HCFA also continued evaluations of a series of HMO demonstrations and an evaluation of the TEFRA HMO and CMP programs.

Among the prior years' projects that continued into FY 1990 were:

Tax Equity and Fiscal Responsibility Act of 1982 Health Maintenance Organization and Competitive Medical Plan Program Evaluation (Mathematica Policy Research, Inc.). The evaluation is designed to examine the impact of the program on HCFA, health care providers, and Medicare beneficiaries.

Social Health Maintenance Organization Project for Long-Term Care (Elderplan, Inc.; Senior Plus; Medicare Plus II; SCAN Health Plan). This Congressionally mandated project (P.L. 98-369 and 100-203) developed and is currently implementing the concept of a social health maintenance organization (S/HMO) for acute and long-term care. A S/HMO integrates health and social services under the direct financial management of the provider of services. All services are provided by or through the S/HMO at a fixed annual prepaid capitation sum.

Medicare Insured Groups (MIGs) (Amalgamated Life Insurance Company, California Edison Company). Under the MIG concept, retiree health benefits, both private and Medicare, are centrally administered under the auspices of a single entity, with Medicare providing funding through a capitated rate. A potential MIG demonstration by the Amalgamated Life Insurance Company is still in the planning stage, as is a new MIG demonstration proposed by the Southern California Edison Company.

Medicare Payments to Health Maintenance Organizations: Beyond a Local Fee-For-Service Methodology (The Urban Institute). This project will investigate whether favorable selection by HMOs in areas of high HMO penetration affects the health status and cost of those Medicare beneficiaries remaining in the fee-for-service sector. If it does, capitation rates set for HMO enrollees may be too high. If such an effect is found, alternatives to current methods for setting capitation rates in high-penetration areas will be explored.

Working Aged Beneficiaries: Program Impacts and Implications for the Adjusted Average Per Capita Cost (Project HOPE Research Center). Because Medicare is the secondary payer for aged persons who are covered by employer medical insurance, HCFA does not complete data on the beneficiaries' medical care use and costs. As a result, the health care costs for the working aged are not fully reflected in the calculations that are made to generate the capitated payments to HMOs under Medicare. This project will develop files that can be used to deter-

mine the magnitude of the problem and any corrective measures that may be necessary.

Developing the Design for a Demonstration of Medicare Payment for Community Nursing Organizations (Project HOPE Research Center). This project is assisting HCFA in designing a demonstration project to provide payment to Community Nursing Organizations for home health services, durable medical equipment, and certain ambulatory care furnished to Medicare beneficiaries on a prepaid, capitated basis.

Alternatives to Fee-For-Service as a Base for Health Maintenance Organization Premium Setting (University of Minnesota Research Center). Currently, HMOs that enroll Medicare beneficiaries under the TEFRA risk contracts are reimbursed 95 percent of eligible costs the enrollees would have incurred if they had remained in the fee-for-service sector. This approach of linking HMO payments to FFS costs (FFS) has been criticized by some on both technical and conceptual grounds. The purpose of this project, therefore, is to develop and analyze alternative methods of reimbursing HMOs for their care of beneficiaries.

Examination of Alternatives to the Adjusted Average Per Capita Cost Geographic Factor (Brandeis University Research Center). The geographic adjuster of the adjusted average per capita cost (AAPCC) is currently a moving 5-year average of the ratio of county costs to national costs. The most recent data entering the five-year average are three years old and the oldest data are eight years old. Thus, this approach may not accurately reflect a county's current status. In addition, it can result in large random year-to-year fluctuations in local AAPCCs, as well as dampen any trends toward increasing or decreasing relative costs in an area. More sophisticated time series methods, which may give a more accurate estimate of counties' current costs relative to national costs, and Baysian methods of reducing random fluctuations, by combining county data with data from a larger area, will be investigated.

Major new initiatives during the year included:

John Deere and Company Medicare Insured Group Research and Demonstration Project (John Deere and Company). John Deere and Company will conduct an initial feasibility study, which includes collecting and analyzing historical trends of the cost and use of Medicare and Deere supplemental retiree benefits. If Deere determines that the MIG concept is a financially feasible venture, it will design the specifics of the MIG demonstration, including the eligible retiree population, benefit package, ratesetting methodology, and qualification of the health care delivery system.

Evaluation of the Municipal Health Services Program (Mathematica Policy Research, Inc.). This project will evaluate the four Municipal Health Services Program (MHSP) demonstrations. (These demonstrations are designed to shift fragmented utilization from costly hospital emergency rooms and outpatient departments toward lower cost MHSP clinics that would provide beneficiaries with comprehensive primary and preventive health care.) The evaluation will determine cost effectiveness, beneficiary costs, and the quality of health services delivered in the MHSP clinics.

Open-Ended Health Maintenance Organizations and Medicare (University of Minnesota Research Center). A recent innovation in the HMO industry is the "open-ended," or "point-of-service," HMO. This project will assess how open-ended HMOs might be coupled with various behavioral incentives to affect utilization, cost, and access and discuss the issues that would need to be addressed in designing a demonstration for Medicare open-ended HMOs.

Hospital Payment ($19.5 million)

HCFA continued to investigate issues related to the refinement and expansion of the PPS during FY 1990, the seventh year of prospective payment. Twenty-three extramural hospital payment studies begun in prior years continued into FY 1990. These studies, which focus on a range of hospital payment issues, include:

Rural Health Transition Grant Evaluation (Mathematica Policy Research, Inc.). Under this study, the contractor will perform both pre-award and post-award functions that include: monitoring a sample of grantees to determine that grants are expended appropriately; conducting an evaluation of the projects funded; and reporting to HCFA the perceived needs of rural hospitals.

Prospective Capital Payment: Refinements and Impacts (Center for Health Economics Research). In 1987, Congress imposed a four-year moratorium on prospective capital payment and mandated that HCFA incorporate capital into PPS by 1992. This project will support HCFA's activities by compiling and analyzing hospital capital statistics from Medicare cost reports.

Medical Assistance Facility Demonstration Project (Montana Hospital Research and Education Foundation). The Foundation is conducting a demonstration of the utility and desirability of medical assistance facilities (MAFs) as a new type of frontier health care facility. MAFs, which provide low-intensity acute care services to short-term inpatients, are intended to maintain access to basic acute and emergency care services.

Natural History of Post-Acute Care for Medicare Patients (University of Minnesota). This is a study of the courses and outcomes of post-acute care. It has two major components: analysis of Medicare data to assess differences in patterns of care across the country and to determine the extent of substitution where various forms of post-acute care services are more or less available; and detailed examination of clinical cases from the most common diagnosis-related groupings receiving post-acute care in a few selected locations.

Hospital Closures, Financial Status, and Access to Care: A Rural and Urban Analysis (Georgetown University). This project addresses why hospitals close and how closures affect access. A hospital-level analysis is being done to examine factors that cause hospitals to close. Closed hospitals will be compared with similar hospitals that remain open with respect to admissions, costs, Medicare and non-Medicare revenues, Medicare patients, and patterns of care. Separate analyses will be conducted for rural and urban areas to identify factors unique to each type of community. A patient-level analysis will compare patients of closed and open hospitals along the following dimensions: diagnostic mix, severity of illness, and patterns of care. In addition, these two groups of patients will be compared to determine whether closure has an adverse effect on access to or outcome of care.

Access to Care in Rural and Inner City America (Center for Health Economics Research). This project is designed to examine changes in utilization trends for 1985 through 1989 in the catchment areas of 23 hospitals that closed inpatient services during 1986-87. The researchers expect to determine whether closures significantly limit access to care for beneficiaries.

Diagnosis-Related Group Outlier Payment Effect on Quality of Care (The RAND Policy Research Center). There are concerns that Medicare reimbursement under the

diagnosis-related group system may induce inappropriate levels of care by paying too much for the outlying patient and too little for the expensive patient who is not an outlier. This research is designed to examine whether outlier payments have any effect on levels and quality of care and what factors are responsible for extremely expensive or long hospital stays.

Health Care for Poor and Rural Hospital Patients (The RAND Policy Research Center). This project will be used to analyze how rural and inner city residents differ from other hospitalized Medicare patients with respect to quality of care, as measured by processes and outcomes adjusted for sickness at admission.

Thirteen new extramural hospital payment research studies were awarded including:

Evaluation of the Ventilator-Dependent Unit Demonstration (Lewin/ICF). Treating ventilator-dependent patients in hospitals is labor intensive, and the cost of the service often exceeds the present payment under PPS. This project will evaluate five competitively-selected demonstration sites that provide care for chronic ventilator-dependent patients. The evaluator will gather data from a representative sample of hospitals as well as the demonstration sites to address such policy concerns as overall cost of care, quality, treatment patterns, and appropriate sites of care.

Changes in Hospital Wages Since Implementation of the Prospective Payment System (Health Economic Research, Inc.). This project examines hospital cost inflation that results from increases in labor costs. Labor costs account for over half of all hospital costs and have been influenced by changes in hospital occupation mix, wage changes in comparable industries, changes in labor productivity, changes in inpatient volumes, and changes in the general inflation level. This project will be used to investigate linkages of these factors to changes in labor costs.

Do Low-Income Patients Have Costlier Hospital Stays? (The RAND Policy Research Center). The purpose of this study is to provide new information about the effect of low-income patients on hospital resource use. If any higher cost is found for low-income patients, the study will suggest the magnitude of the PPS adjustment that would be supported by the severity argument alone.

Examination of Alternative Approaches for Graduate Medical Education Payment Through Medicare (Project HOPE Research Center). The objectives of this task are to analyze Medicare's methodology of payment for direct and indirect graduate medical education costs and to recommend alternative payment options. Alternatives could include incentives to encourage training in primary, preventive, geriatric, and ambulatory care; establishment of practices in rural and medically-underserved areas; and recruitment of residents from minority and disadvantaged backgrounds.

Monitoring Hospital Closures, Mergers, Openings, and Changes in Ownership (Brandeis University Research Center). To fulfill its responsibility to monitor changes in the hospital industry that could affect Medicare beneficiaries, HCFA needs accurate and timely information on the number of and trends in hospital closures, mergers, openings, and ownership changes. Under this project, Brandeis will design a strategy that HCFA can use to acquire and maintain detailed knowledge of these changes on an annual basis.

The Potential Use of Hospital Choice Models in Analyzing Essential Access Community Hospital and Rural Primary Care Hospital Designations (Brandeis University Research Center). Brandeis will present conceptual arguments on the strengths and weaknesses of alternative hospital choice models and their potential use in analyzing

designations of Essential Access Community Hospitals (EACHs) and Rural Primary Care Hospitals under the EACH program.

Program Efficiences, Anayyses and Refinements ($4.5 million)

Congress has prompted major changes in the past few years to improve the effectiveness and efficiency of the Medicare program. Research on and evaluation of these changes, as well as on factors influencing program performance, provide the information on health care expenditures and utilization patterns of Medicare beneficiaries necessary to achieve more cost-effective program operations. Essential to this effort is the improvement of existing Medicare data bases. Several aspects of program performance also have been studied to improve understanding of them. Factors influencing utilization of particular types of services and the characteristics of certain categories of beneficiaries continue to be examined. Fifty-one projects from previous years continued into FY 1990, including:

Medicaid Tape-to-Tape: Research Data and Analysis (SysteMetrics, Inc.). This project continues the development and implementation of a Medicaid person-level data set from the five State Medicaid Management Information Systems in California, Georgia, Michigan, New York, and Tennessee. This project will provide a continuum of nine years of uniform Medicaid data for the conduct of analysis of program management, evaluation of policy alternatives, and feedback to States in the area of Medicaid financing.

Predictors of Cost and Success in Kidney and Heart Transplantation (Battelle Human Affairs Research Centers). This project examines the patient and organizational characteristics that determine successful kidney and heart transplantation outcomes. Using multivariate life-table methods, data from the Medicare program will be combined with information from surveys of transplant facilities to construct a model of transplant facility effectiveness.

International Comparative Data and Analyses on Health Care Financing and Delivery Systems (The Organization for Economic Cooperation and Development). The focus of this project is on developing, updating, and refining an internationally comparable data base on health care spending patterns, prices, utilization, and delivery system characteristics. Data developed under this contract provide the best possible contemporary basis for performing cross-national comparisons of health systems.

Evaluation of the Alcoholism Service Demonstration (MayaTech Corp.). This project requires a report on the effectiveness of the demonstration that expanded Medicare and/or Medicaid coverage to freestanding alcoholism treatment centers. The contractor will examine the impact of the demonstration on the use and cost of services.

Small Business Innovation

Under the Small Business Innovative Research (SBIR) program (P.L. 97-219), HCFA continued its funding of several low-cost studies. Among these were:

Diagnosis-Related-Group-Specific Resource Management Software for Hospitals (John Rafferty and Associates). The objective of the project is to create a software package (which is currently under development) for predicting and evaluating hospital resource use and needs on a DRG-group basis.

Acquired Immunodeficiency Syndrome Comprehensive Monitoring System Pilot Project (Research Consultants). This project has four objectives:

- To identify the service components and the source of payment for Acquired Immune

Deficiency Syndrome (AIDS) and AIDS-related complex patients who receive care in alternative settings and develop a software package reflecting these data for use by providers.

- To identify the services that are requested but are not available in alternative-care programs.
- To develop standard protocols for collecting units of service use and cost data in AIDS alternative-care settings.
- To develop a microcomputer-based system for monitoring and managing AIDS patients' costs in alternative settings.

Utilization Management Techniques for Physicians' Services and Non-Physician Ambulatory Services (Center for Health Policy Studies). This is a project to prepare a practical guidebook that identifies and assesses the performance of private sector programs to monitor and reduce excess utilization of physician and ambulatory services. The focus will be on programs that are particularly suited to Medicare and its utilization experience.

Development of New Automatic Interactions Detection Software (Austin Data Management Associates). This project will develop a new computer software package to perform automatic interactions detection (AID). AID was used in the development of the Medicare hospital payment system based on diagnosis-related groups. AID is being used in the development of case-mix classification systems. The proposed product will vastly improve the ability of a user who is not a programmer to operate AID.

Development of a Tool for Assessing Hospital Bed Needs in Rural Communities (Laguna Research Associates). This project will develop an empirical model of hospital utilization that can be used by rural communities to assess bed needs in a community and, thereby, assist in their long-range planning.

Analysis of Medicare Expenditures for Ambulance Services (Project HOPE Research Center). This project is designed to analyze spending for ambulance services under Medicare. Both the nature and composition of spending for ambulance services and the amount of ambulance services used by beneficiaries with different characteristics will be examined. An attempt will be made to measure the difference between Medicare payments for basic ambulance transportation and the payments that would have been made had other transportation alternatives been used.

In FY 1990, HCFA also funded 14 new studies. Among these were:

Cost and Outcomes from Different End Stage Renal Disease Treatment Modalities (The Urban Institute). This project will study the cost-effectiveness of different treatment regimens for end stage renal disease and will compare quality of life indicators for these regimens.

Medicare Beneficiary Health Status Registry (Research Triangle Institute). The Medicare Beneficiary Health Status Registry will be a longitudinal data base combining survey data on the elderly with Medicare's administrative data files. The survey data will be collected through telephone interviews with 5 percent of the elderly as they enter the Medicare program and at five-year intervals thereafter.

Improving the Quality of Medical Care Documentation Using Voice-Activated Word Processors (Birch and Davis Associates). This project will examine the acceptance by physicians of using a voice-activated word processor to document medical records data.

A Planning Process for Changing Rural Health Care Delivery Systems (Public Health Resource Group). This project is developing a written set of planning protocols, statistical algorithms, and computer software to assist

rural hospitals and their communities in evaluating the efficacy and financial condition of the hospitals and the health care delivery system.

Use of Market Force Dynamics to Set Medicare Fee Schedules (Project HOPE Research Center). This project has two major objectives. The first is to examine the potential for using market force dynamics to set Medicare fee schedules that approximate the prices that would be charged in a competitive market. The second objective is to review a Medicare demonstration project that is designed to evaluate competitive bidding for clinical laboratory service. This demonstration project was designed in 1987, but not implemented. An assessment will be made as to whether the design is still appropriate in light of changes in the industry since the demonstration was originally proposed.

Description and Analysis of State Medicaid Drug Benefits (The RAND Policy Research Center). The overall goals of this project are to summarize existing knowledge on the economic and quality of care effects of alternative cost-containment methodologies utilized in the Medicaid program; to define high-priority information needs in these areas; and to propose research methodologies and topics to provide needed information on the impact of specific policies.

Design of Interventions to Reduce Drug-Related Adverse Events Among Community-Resident, Elderly Medicaid and Medicare Patients (University of Minnesota Research Center). The knowledge base on the causes of drug-related adverse events is now substantial enough to warrant a research program on the cost-effectiveness of interventions to reduce the incidence of such events. The project will assess the costs of acute health care services covered by public programs, relative to the costs of implementing an intervention.

Health Care Prevention and Access ($3.5 million)

Current coverage rules governing Medicare do not allow reimbursement for most preventive services. HCFA, however, continues through its research to maintain an interest in the potential beneficial effects of particular preventive medical services and beneficiary access to services. Fifteen extramural projects from previous years continued into FY 1990, including:

Evaluation of the Omnibus Budget Reconciliation Act of 1987 Medicare Payment for Therapeutic Shoes for Individuals with Severe Diabetic Foot Disease Demonstration (Mathematica Policy Research, Inc.). The demonstration tests the cost effectiveness of furnishing therapeutic shoes to Medicare beneficiaries with severe diabetic foot disease. The demonstration utilizes a randomized design with equal numbers of treatment group and control group beneficiaries.

Health Care Services for Children Under Medicaid (The Johns Hopkins University). This is a comparative study of health care services for children by using billing claims and eligibility data files from the State of Maryland. Information on the cost and effectiveness of services for children eligible for the Medicaid Early and Periodic Screening, Diagnosis, and Treatment program will be sought and data on the costs and utilization of services for children using private practitioners, hospital clinics, emergency rooms, and various combinations of delivery systems will serve as the basis of comparison for this analysis.

Analysis of the Health Care Financing System (Lewin/ICF). This project will address the Presidential Directive from the AIDS Commission to conduct an analysis of the health care financing system. The study focuses on access to adequate health care by the American public under the current system

of health care financing. Alternatives for the uninsured and the underinsured will be developed; the fiscal impacts of these strategies, as well as the utility of the strategies for policymaking will be analyzed.

Prevention Studies

Section 9314 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA 85) requires the Secretary to conduct, evaluate, and report on demonstration programs designed to reduce disability and dependency through the provision of preventive health services to beneficiaries. In partial response to this mandate, the following studies were initiated:

Cost Utility of Medicare Reimbursement for Preventive Services in a Health Maintenance Organization (University of Washington School of Public Health and Community Medicine). This project is implementing a randomized design to assess the cost savings and changes in health-related quality of life associated with providing a preventive-service package (annual health risk assessment, individual health promotion, and group counseling) for Medicare beneficiaries enrolled in Group Health Cooperative of Puget Sound.

Preventive Health Services for Medicare Beneficiaries: Demonstration and Evaluation (The Johns Hopkins University). This demonstration is providing preventive services to a representative population of beneficiaries residing in the eastern half of Baltimore City. The University will also conduct a comprehensive evaluation to assess the cost effectiveness of providing preventive services.

Preventive Health Services for Medicare Beneficiaries (University of Pittsburgh). This demonstration is providing preventive services to beneficiaries residing in rural counties in western Pennsylvania. The University will also conduct a comprehensive evaluation to assess the cost effectiveness of providing preventive services.

Preventive Health Services for Medicare Beneficiaries, San Diego Demonstration Project (San Diego State University Foundation). Approximately 1,800 Medicare patients currently enrolled in the Secure Horizons HMO have been randomly assigned to either a treatment or a control group. The San Diego School of Public Health will conduct a comprehensive evaluation to assess the cost effectiveness of providing preventive services.

University of California, Los Angeles, Medicare Prevention Demonstration (University of California). Approximately 2,100 beneficiaries who are current patients of the University of California, Los Angeles, university-based clinic have been randomly assigned to either a treatment or a control group, with a subsequent evaluation to assess the cost effectiveness of providing preventive services.

Twelve new projects were funded during the fiscal year, including:

Evaluation of the Cost-Effectiveness of Medicare Coverage of Influenza Vaccine (Abt Associates, Inc.). The objective of this project is to evaluate the cost-effectiveness of furnishing an influenza vaccination as a Medicare-covered benefit, as mandated by P.L. 100-203.

Analyzing Durations of Spells Without Health Insurance: How Many People Have Chronic Versus Short-Term Spells? (Brandeis University Research Center). This project will analyze the durations of spells without health insurance and the determinants of chronic as well as short uninsured spells. This is a topic of increasingly critical importance as the nation begins to assess various policy alternatives for providing financial access to the uninsured population.

Access to Kidney Transplantation: An Examination of the Decision to Transplant (The RAND Policy Research Center). This project will analyze the effect of the medical and social characteristics of both the organ donor and potential transplant recipient on the

probability of receiving a kidney transplant. RAND will conduct a comprehensive examination of the medical and nonmedical reasons for placing or not placing a donated cadaver kidney into a particular individual when that individual is next in line to receive a transplant. Specifically, RAND will identify the key factors that determine when an individual will receive a cadaver kidney at kidney transplant centers across the country.

Subacute and Long-Term Care ($5.9 million)

HCFA continues to investigate and has expanded its examination of issues relating to subacute and long-term care. Studies focus primarily on the areas of: alternative payment and delivery, long-term care populations, and case-management studies. A total of 38 studies initiated in previous years continued into FY 1990, including:

Efficacy of Nursing Home Preadmission Screening (Brown University). The purpose of this project is to evaluate a nursing home preadmission screening methodology developed to identify those persons who would be institutionalized if community-based services were not available. The project is analyzing the extent to which the screen accurately predicts the need for a nursing home level of care or an equivalent level of community care.

Research on Acquired Immunodeficiency Syndrome Cost and Utilization Experience in New York and California Medicaid Programs (SysteMetrics, Inc.). The purpose of this project is to:

- Use epidemiological techniques to produce incidence analysis of AIDS over a 4 1/2-year (10/82 - 3/87) period.
- Study the eligibility patterns of AIDS patients in Medicaid.
- Develop a disease-staging algorithm for AIDS Medicaid patients.
- Provide a utilization and cost analysis of the population.

The first year of this study has been devoted to efforts concentrated on methodological activities such as: developing common definitions for key variables; constructing data files for research; and refining the disease-staging algorithm for AIDS.

Evaluation and Technical Assistance of the Medicare Alzheimer's Disease Demonstration (Institute for Health and Aging). The Medicare Alzheimer's Disease Demonstration, authorized by Congress under P.L. 99-509, will determine the effectiveness, cost, and impact on health status and functioning of providing comprehensive services to beneficiaries who have dementia. Two models of care are being studied under this project. Both provide case management, homemaker/personal care services, adult day care, and education and counseling for family caregivers. Case management activities include assessment, care planning, service arrangement, and patient monitoring. The two models vary by their monthly expenditure caps and the intensity of their case management. Eight sites are participating in this demonstration.

Long-Term Care Studies (Health and Sciences Research Incorporated). This project is conducting research related to the delivery and financing of long-term care services for Medicare beneficiaries. The project focuses on financial impacts on beneficiaries and their families when long-term care services are required, beneficiary characteristics that affect utilization of long-term care services, and how the provision of long-term care services may reduce expenditures for acute-care services.

Evaluation of the Arizona Health Care Cost-Containment System (Laguna Research Associates). This project will evaluate the continuing operation of the Arizona Health Care Cost-Containment System (AHCCCS), with particular emphasis on the implementation and operation of the Arizona Long-Term Care System, a new component of AHCCCS.

Financial Impact to Beneficiaries of Nursing Home Care (Brandeis University Research Center). The project used the Urban Institute's Transfer Income Model (TRIM)-2 for State estimates and the Connecticut Nursing Home Inventory data base to calculate nursing home use and payments. In addition, the 1985 National Nursing Home Survey was used to analyze several dimensions of nursing home use. From the collected data, estimates for the nursing home patients' spend-down provision were made.

Goals and Strategies for Financing Long-Term Care (University of Minnesota Research Center). This study will use concepts drawn from a number of disciplines—economics, decision sciences, policy analysis, sociology, and demography —to develop statements of possible objectives for long-term care insurance. Defining objectives will include an analysis of benefits and costs from potential changes in financing and an analysis of expected behavioral changes in response to changes in financing.

Analysis of Cost, Patient Characteristics, Access, and Service Use in Urban/Rural Home Health Agencies (University of Minnesota Research Center). The purpose of this project is to study urban and rural differences in home health agency costs, patient characteristics, access to care, and service utilization patterns.

Activities of Daily Living Measurements as Determinants of Eligibility (Brandeis University Research Center). This study will examine issues associated with defining and measuring activities of daily living (ADLs) for use as eligibility criteria for Medicare services. A cost analysis will be performed and other issues associated with using ADL scores as eligibility criteria will be discussed.

In addition, 22 new studies were initiated during this fiscal year. The new studies include:

Frail Elderly Demonstration: The Program for All-Inclusive Care for the Elderly (East Boston Geriatric Services, Inc.; Providence Medical Center; Beth Abraham Hospital; Richland Memorial Hospital; Community Care Organization of Milwaukee County, Inc.). As mandated by Congress, HCFA will conduct a demonstration replicating the model of care developed by On Lok Senior Health Services in San Francisco, California. The PACE demonstration replicates a unique model of managed-care service delivery for 300 to 500 very frail community-dwelling elderly, most of whom are dually-eligible for Medicare and Medicaid coverage and all of whom are assessed as being eligible for nursing home placement according to the standards established by participating States. The model of care includes as core services the provision of adult day healthcare and multidisciplinary case management through which access and allocation of all health and long-term care services are arranged.

Policy Study of the Cost Effectiveness of *Institutional Subacute Care Alternatives and Services: 1984-92* (University of Colorado). The University will assess which subacute institutional settings and combinations of services are most cost-effective and provide more positive outcomes for various types of patients. The project will identify potential HCFA policy changes that might encourage use of the most appropriate settings and services.

Implementation of Home Health Agency Prospective Payment Demonstration (Abt Associates, Inc.). This project will implement a demonstration testing alternative methods of paying home health agencies on a prospective basis for services furnished under the Medicare program. The demonstration will test two prospective payment approaches: payment per episode of Medicare-covered home health care and payments per visit by type of discipline.

Bundling of Acute and Post-Acute Care Service (University of Minnesota Research Center). This project will examine the concept of bundling payment for acute and post-acute care services into payment for an episode of care. HCFA is interested in developing alternative approaches that would encourage organizations to manage an entire episode of care under a payment arrangement other than fee-for-service. The University will prepare a report on the feasibility of different design options.

High-Cost Hospice Care (Project HOPE Research Center). The purpose of this project is to identify what Medicare hospice services are high-cost, determine or estimate the average cost of these services, and ascertain from a panel of clinical experts dimensions of use of high-cost procedures.

Implementing Federal Regulations in Nursing Homes: A Conceptual Paper (University of Minnesota Research Center). The purpose of this project is to develop a conceptual paper on the issues involved in regulating the use of psychoactive drugs in nursing homes, the range of problems that the long-term care community and HCFA surveyors might face in implementing these regulations, the quality of large-scale data bases available for examining these issues and problems, and the research designs that would be most appropriate for studying the impact of HCFA guidelines on the use of psychoactive drugs by nursing home elderly.

Impacts of Long-Term Care Supply Differences on Medicare Service Use (Brandeis University Research Center). This study will identify and assess methodological and practical problems associated with a potential investigation of access to long-term care services and the resulting impact on beneficiary use of Medicare-covered services.

Rural Health Care Transition Grants Program

Under the Rural Health Care Transition Grants Program mandated by Public Law 100-203, as amended by Public Law 101-239, HCFA awarded 212 grants to 211 small rural hospitals in FY 1990.

This program is designed to provide assistance to small rural hospitals and their communities in planning and implementing projects to strengthen the capability of these hospitals to provide high quality care to Medicare beneficiaries. Under the program, eligible rural hospitals could request up to $50,000 per year for up to three years to support projects intended to adjust for one or more of the following factors:

- Changes in clinical practice patterns.
- Changes in service populations.
- Declining demand for acute care inpatient hospital capacity.
- Declining ability to provide appropriate staffing for inpatient hospital services.
- Increasing demand for ambulatory and emergency services.
- Increasing demand for appropriate integration of community health services.
- The need for adequate access to emergency care and inpatient care in areas in which a significant number of underutilized hospital beds are being eliminated.

Hospitals qualified for this program if they were non-Federal, not-for-profit, short-term general acute care hospitals, located in rural areas (i.e., currently being paid as rural hospitals under Medicare PPS) and had fewer than 100 available beds (as defined on the Medicare cost report).

In designing the grant program and solicitation materials, HCFA consulted with the Public Health Service's Office of Rural Health Policy, the American Hospital Association, the National Rural Health Association, the National Governors' Association, and the National Association of Counties.

HCFA received 602 applications in response to solicitation announcements and application materials that were mailed to each rural hospital. Three hundred and four applications were submitted by hospitals applying as individual facilities; 198 were submitted by hospitals applying as part of a consortium (a total of 50 consortia applied). Applications were received from each State, except Massachusetts, Alaska, and Hawaii, in which there were eligible rural hospitals.

Each application was reviewed for technical merit by a panel of experts. The panel's recommendations were taken into consideration in determining the projects to be awarded. Congress appropriated $17.76 million in FY 1990 to fund this grant program (including the independent evaluation of the effectiveness and impact of the program). The appropriation included $16.8 million to fund grants made under this program, both new awards and second year continuation funding for grants made in FY 1989. A total of 174 FY 1989 awardees requested and received second year continuation funding totalling $7.4 million. Of the 212 new awards, 151 were to hospitals applying as part of a consortia (16 consortia). Funding for new awards totalled $9.4 million. Each State with eligible hospital applicants received at least one award.

Reports to Congress

In FY 1990, HCFA's Office of Research and Demonstrations prepared 11 reports to Congress on various mandated studies and activities.

- *Relative Value Scales* (P.L. 99-509, Sec. 9331(e); P.L. 99-272, Sec. 9305;P.L. 100-203, Sec. 4045(b))
- *Study of Issues Relating to Volume and Intensity of Physician Services* (P.L. 100-203, Sec. 4056(c)(2))
- *1987 Annual PPS Impact Report* (P.L. 98-21, Sec. 603(a)(2)(A))
- *Study of Payment for Administratively Necessary Days* (P.L. 99-509, Sec. 9305(e))
- *Grant Program for Rural Health Care Transition* (P.L. 100-203, Sec. 4005(e))
- *Rural Secondary Specialty Demonstration Project* (P.L. 99-506, Sec. 9302(d)(4))
- *Prior and Concurrent Authorization* (P.L. 99-509, Sec. 9305(k))
- *Medicare Fee Schedule on Eligible Risk-Sharing Organizations* (P.L. 101-239, Sec. 6102(a))
- *Development of a Prospective Payment Methodology for Outpatient Services* (P.L. 99-509, Sec. 9343(f))
- *Health Maintenance Organizations — Disenrollment Study (Final Report)* (P.L. 97-248, Sec. 114(e))
- *Demonstration of Cost Effectiveness of Provision of Therapeutic Shoes* (P.L. 100-203, Sec. 4072(e)(2)(B)(i))

Chapter VI

Promoting Improvements in HCFA

Introduction

In FY 1990, HCFA had 3,915 employees working at its central office in Baltimore, Maryland, executive offices in Washington, D.C., and 10 regional offices. Their varied assignments included policy development, program operations, legislative analysis and liaison activities, health care research and demonstrations, budget preparation and analysis, actuarial studies, data collection and processing, enforcing health care quality standards, and public information activities. These activities are overseen by an administrator who is assisted by a deputy administrator and associate administrators for management, operations, program development, and communications. The regional offices, which are managed by regional administrators, are located in Atlanta, Boston, Chicago, Dallas, Denver, Kansas City, New York, Philadelphia, Seattle, and San Francisco.

The number of General Schedule and General Merit (GS/GM) positions in the 13 to 15 grade band increased during the fiscal year from 1,609 to 1,658. The number of minorities in these positions increased from 200 to 210, with the number of Black females rising from 81 to 91, Asian-American females from 6 to 8 and white females from 406 to 443.

Procurement Goals

HCFA pursued departmental procurement preference and competition goals in the awarding of more than $1.1 billion in contracts during FY 1990. A summary of the goals and HCFA's actual performance in each of six procurement categories as shown in Table 4.

Office Automation

HCFA accomplished numerous automation initiatives to increase effectiveness and improve retrieval of information. For example, the automated Comprehensive Personnel System was improved by establishing program controls to prevent input errors, updating the subsystems to reflect revised processing procedures, and by developing a new program to track Employee Performance Management System (EPMS) bonuses. The Agency was also involved during the fiscal year in a detailed analysis of long-range systems requirements as part of an overall systems modernization initiative.

Table 4

	CATEGORY	GOAL	ACTUAL	TOTAL DOLLARS
1	Small Business	52.2%	45.61%	$30,837,634
2	8(a)	25.0%	24.25%	16,601,323
3	*Direct Minority	1.0%	.74%	503,238
4	Women-owned Business	4.1%	8.77%	5,932,643
5	Labor Surplus Area	4.1%	4.70%	3,182,964
6	Competitive	80.0%	86.99%	53,627,785

* Because there is no mandated set-aside for direct awards to minority firms, achievement of this goal was primarilydependent upon the minority vendors submitting proposals for and winning competitively bid contracts.

In conjunction with the improvements to the automated systems, HCFA employees were provided with a variety of computer training courses, including instruction in wordprocessing, and spreadsheet and database applications on personal computers. The increased use of automation has promoted efficiency in the personnel operations of the Agency.

Recruiting Intitiaves

In an effort to meet the increased need to recruit and retain qualified personnel, HCFA continued efforts to strengthen its recruitment programs. Several new recruitment authorities were obtained from the Office of Personnel Management (OPM), including Delegated Examining Authority and the Professional and Administrative Career Schedule B Authority. These authorities should provide managers with increased hiring flexibility and are expected to expedite the recruiting process. HCFA continued to expand its Cooperative Education Program and focused on methods of attracting health care curriculum graduates and minority students. Extensive negotiations were concluded with the Department of Health and Human Services regarding HCFA's proposed request for special salary rates for actuaries at the GS-5 through the GS-11 level. The request is now before OPM.

Presidential Management Intern Program

A comprehensive program was conducted by HCFA in support of the Office of Personnel Management's Presidential Management Intern Program (PMI). Twenty-one interns at HCFA were provided mentors, individual developments plans, training, seminar services, and rotational assignments. The PMI program provides an excellent source for recruiting high calibre individuals with potential to assume management positions with the Agency.

Promoting Health Wellness and Fitness Programs

In recognition of the positive impact a healthy workforce can have on employee morale and productivity, HCFA developed an integrated approach to its health, wellness, and fitness programs. The occupational health, health benefits, Employee Assistance Program (counseling), fitness center support, health/drug abuse education, and child care referral functions were all incorporated into one organization in an effort to eliminate duplication and improve communication. A variety of health and education programs were implemented, including health screenings, (cholesterol, blood pressure, etc.), training classes for managers and supervisors, and desk-to-desk distribution of informational materials. HCFA also made efforts to improve coordination between the Employee Assistance Program and the disciplinary process. It is anticipated that this will improve supervisory sensitivity to the various personal problems faced by employees.

Equal Employment Opportunityu Accomplishments

HCFA's work force decreased by 62 during the fiscal year to 3,915. At the same time, the representation of minorities and non-minority women in the GS/GM 13-15 grade band increased from 25.2 to 26.7 and 12.4 to 12.6, respectively.

Of the 15 transitional positions maintained by the Agency in FY 1990, 9, or 60 percent, were assigned to minorities and one to a severely handicapped individual. Transitional positions are intended to prepare lower-graded staff for movement into higher positions through formal training and job experience.

Table 5

EQUAL EMPLOYMENT OPPORTUNITY ACCOMPLISHMENTS

	FY90	%	FY89	%
HCFA Workforce	3,915		3,977	
GS/GM 13-15 Grade Band	1,658		1,609	
Minorities	210	12.6	200	12.4
Non-Minority Females	443	26.7	400	25.2
Transitional Positions	15		6	
Minorities	9	60.0	2	33.0
Employees with targeted Disabilities	45	1.1	49	1.2

CHAPTER VII

Regulations Published in FY 1990

Listed below are the various regulations affecting the Medicare and Medicaid programs published in the Federal Register during FY 1990. The date of publication appears in the column on the left and the page at which the item was printed is shown at the end of the title.

DATE	TITLE
10/02/89	Medicare and Medicaid Programs; Meeting of the Quadrennial Advisory Council on Social Security (pg. 40527)
10/11/89	Medicare as Secondary Payer and Medicare Recovery Against Third Parties (pg. 41716)
10/13/89	Medicaid Program; Medicaid Management Information System: Revised Definition of "Mechanized Claims Processing and Information Retrieval System" (pg. 41966)
10/25/89	Medicare Program, Data, Standards and Methodology Used to Establish Budgets for Fiscal Intermediaries and Carriers (pg. 43493)
10/26/89	Medicare Program; SNF Coinsurance Amount for 1990 (pg. 43619)
10/27/89	Medicare Program; Monthly Actuarial Rates, Supplementary Medical Insurance Premium Rate, and Catastrophic Coverage Premium, Beginning January 1, 1990 (pg. 43862)
11/06/89	Medicare Program; Physician Involvement in Physical Therapy and Speech Pathology Services; Correction(pg. 46614)
11/08/89	Medicare Program; Payment for Home Intravenous Drug Therapy Services (pg. 46938)
11/08/89	Medicare Program; Outpatient Prescription Drugs; List of Covered Home IV Drugs-Extension of Public Comment Period (pg. 46988)
11/08/89	Medicare Program; Catastrophic Outpatient Drug Benefit-Extension of Public Comment Period (pg. 46937)
11/16/89	Medicare Program; Medicare as Secondary Payer and Medicare Recovery Against Third Parties; Publication of Court Orders (pg. 47678)
11/22/89	Medicare Program; Part A Premium for the Uninsured Aged for 1990 (pg. 48322)
11/24/89	Medicare and Medicaid Programs; Coordination and Maintenance Committee Meeting (pg. 48689)
11/24/89	Medicare and Medicaid Programs; Meeting of the Advisory Council on Social Security (pg. 48689)
12/07/89	Medicare Program; Monthly Actuarial Rates, Supplementary Medical Insurance Premium Rate, and Catastrophic Coverage Premium, Beginning January 1, 1990; Correction (pg. 50581)
12/11/89	Medicaid Program; Eligibility Determinations Based on Disability (pg. 50755)
12/11/89	Medicare Program; Claims Payment Cycle (pg. 51008)
12/18/89	Medicare and Medicaid Programs; Organ Procurement and Transplantation Network Rules and Membership Actions (pg. 51802)
12/29/89	Medicare Program; Physician Performance Standard Rate of Increase for Federal Fiscal Year 1990 (pg. 53818)

DATE	TITLE
12/29/89	Medicare and Medicaid Programs; Requirements for Long-Term Care Facilities: Delay in Effective Date of Regulations (pg. 53611)
12/29/89	Medicare Program; Legislative Changes Concerning Payment to Hospitals for Federal Fiscal Year 1990 (pg. 53753)
01/04/90	Changes in Payment Policy for Direct Graduate Medical Education (pg. 290)
01/16/90	Medicaid Program; State Plan Requirements and Other Provisions Relating to State Third Party Liability Programs (pg. 1423)
01/17/90	Medicare Program; Carrier Bonuses for Increasing Physicians' Participation or Payments (pg. 1619)
01/19/90	Medicare as Secondary Payer and Medicare Recovery Against Third Parties (pg. 1819)
01/19/90	Medicaid Program; Medicaid Management Information System: Revised Definition of "Mechanized Claims Processing and Information Retrieval System" (pg. 1820)
01/26/90	Medicare and Medicaid Programs; Meeting of the Advisory Council on Social Security (pg. 2704)
02/01/90	Medicare Program; Establishment of Medicare Economic Index, Effective April 1, 1990 (pg. 3487)
02/08/90	Medicare Program; Revision of Ambulatory Surgical Center Payment Rate Methodology (pg. 4526)
02/08/90	Medicare Program; Update of Ambulatory Surgical Center Payment Rates (pg. 4577)
02/09/90	Medicaid Program; State Share of Financial Participation (pg. 4626)
02/13/90	Medicaid Program; State Plan Requirements and Other Provisions Relating to State Third Party Liability Programs; Correction (pg. 5118)
02/20/90	Medicare Program; Updated HMO Qualification Determinations (pg. 5894)
02/21/90	Medicaid Program; Prohibitions on FFP for Educational and Vocational Training for Institutionalized Individuals (pg. 6015)
03/08/90	Medicare Program; Medicare Secondary Payer for Disabled Active Individuals (pg. 8491)
03/08/90	Medicare Program; Criteria for Medicare Coverage of Adult Liver Transplants (pg. 8545)
03/14/90	Medicare, Medicaid and CLIA Programs; Revision of the Laboratory Regulations for the Medicare, Medicaid, and Clinical Laboratories Improvement Act of 1967 Programs (pg. 9538)
03/15/90	Medicare Program; Catastrophic Outpatient Drug Benefit, Home Intravenous Drug Therapy Benefit, and Screening Mammography Services-Withdrawal (pg. 9740)
3/15/90	Medicare Program; Outpatient Prescription Drugs: List of Covered Home IV Drugs Withdrawal (pg. 9774)
3/19/90	Medicaid Program; Payment Adjustments for Hospitals That Serve a Disproportionate Number of Low-Income Patients (pg. 10077)
03/19/90	Medicare Program; Changes to Maintenance of Effort Requirements (Section 421 of the Medicare Catastrophic Coverage Act) (pg. 10116)
03/20/90	Medicare and Medicaid; Charges to Residents' Funds in Nursing Homes (pg. 10256)
03/20/90	Quarterly Listing of Program Issuances and Coverage Determinations (pg. 10290)
03/23/90	Medicare and Medicaid Programs; Preadmission Screening and Annual Resident Review (pg. 10951)

DATE	TITLE
03/23/90	Medicare and Medicaid Programs; Nurse Aide Training and Competency Evaluation Programs (pg. 10938)
03/26/90	Medicare Program; Medicare as Secondary Payer and Medicare Recovery Against Third Parties (pg. 11019)
03/28/90	Medicare Program; Physician Involvement in Physical Therapy and Speech Pathology Services (pg. 11372)
03/29/90	Medicare and Medicaid Programs; Coordination and Maintenance Committee Meeting (pg. 11657)
04/05/90	Quarterly Listing of Program Issuances (pg. 12737)
04/10/90	Medicare Program; Withdrawal of Coverage of Extracranial-Intracranial Arterial Bypass Surgery for the Treatment or Prevention of Stroke (pg. 13321)
04/10/90	Medicare Program; Monthly Supplementary Medical Insurance Premium, Beginning January 1, 1990 (pg. 13324)
04/17/90	Medicare Program; Changes to the Inpatient Hospital Prospective Payment System and FY 1990 Rates; Correction and Technical Amendment (pg. 14282)
04/17/90	Medicare, Medicaid and CLIA Programs; Revision of the Laboratory Regulations for Medicare, Medicaid, and Clinical Laboratories Improvement Act of 1967 Programs; Correction (pg. 14378)
04/20/90	Medicare Program, Fiscal Year 1990; Mid-year Changes to the inpatient Hospital Prospective Payment System; Final Rule with Request for Comments (pg. 15150)
05/02/90	Medicare Program; Protocol for the Reuse of Dialysis Bloodlines (pg.18331)
05/02/90	Criteria and Standards for Evaluating Intermediary and Carrier Performance (pg. 18391)
05/03/90	Medicare Program; Definition of Surgical Services (pg. 18668)
05/09/90	Medicare Program; Changes to the Inpatient Hospital Prospective Payment System and Fiscal Year 1991 Rates (pg. 19426)
05/16/90	Criteria and Standards for Evaluating Intermediary and Carrier Performance; Correction (pg. 20391)
05/21/90	Medicare, Medicaid and CLIA Programs; Regulations Implementing the Clinical Laboratory Improvement Amendments of 1988 (CLIA '88) (pg. 20896)
05/22/90	Medicare and Medicaid Programs; Meeting of the Advisory Council on Social Security (pg. 21109)
05/23/90	Medicare Program; Withdrawal of Coverage for Certain Investigational Intraocular Lenses (pg. 21250)
05/31/90	Medicaid Program; Medicaid Eligibility Quality Control (MEQC) Program Requirements (pg. 22142)
06/04/90	Medicare Program; Medicare Coverage of Hepatitis B Vaccine for High and Intermediate Risk Individuals, Hemophilia Clotting Factors and Certain X-ray Services (pg. 22785)
06/07/90	Medicare and Medicaid Programs; Meeting of the Advisory Council on Social Security (pg. 23299)
06/08/90	Medicare Program; Payment for Physician Outpatient Maintenance Dialysis Services and Other Physician Services for ESRD Patients (pg. 23435)
06/12/90	Waiver of Certain Membership Requirements for Certain Health Maintenance Organizations (HMOs), and State Option for Disenrollment Restrictions for Certain HMOs Under Medicaid (pg. 23738)

DATE	TITLE
06/14/90	Medicare Program; Inpatient Hospital Deductible and Coinsurance and Skilled Nursing Facility Coinsurance for 1990 (pg. 24159)
06/18/90	Medicare Program; Physician Liability on Non-Assigned Claims (pg. 24561)
06/22/90	Waiver of Certain Membership Requirements for Certain Health Maintenance Organizations (HMOs), and State Option for Disenrollment Restrictions for Certain HMOs Under Medicaid; Correction (pg. 25774)
06/22/90	Medicaid Program; Medical Eligibility Quality Control (MEQC) Program Requirements; Correction (pg. 25773)
07/05/90	Medicare Program; Update of Ambulatory Surgical Center Payment Rates, Effective July 1, 1990 (pg. 27690)
07/09/90	Quarterly Listing of Program Issuances (pg. 28101)
07/20/90	Medicare and Medicaid Programs; Meeting of the Advisory Council on Social Security (pg. 29674)
07/24/90	Medicare and Medicaid Programs; Coordination and Maintenance Committee Meeting (pg. 30036)
08/01/90	Medicare Program; Medicare Coverage of Hepatitis B Vaccine for High and Intermediate Risk Individuals Hemophilia Clotting Factors and Certain X-ray Services (pg. 31185)
08/01/90	Medicare/Medicaid Programs; Fire Safety Standards for Hospitals, Long Term Care Facilities, and Intermediate Care Facilities for the Mentally Retarded (pg. 31196)
08/03/90	Clinical Laboratory Improvement Act Programs; Fee Collection; (pg. 31758)
08/07/90	Revision of Ambulatory Surgical Center Payment Rate Methodology; Medicare Program (pg. 32150)
08/07/90	Medicare Program; Uniform Relative Value Guide for Anesthesia Services Furnished by Physicians (pg. 32078)
08/07/90	Medicare Program; Update of Ambulatory Surgical Center Payment Rates; Correction (pg. 32150)
08/07/90	Medicare Program, Fiscal Year 1990; Mid-Year Changes to the Inpatient Hospital Prospective Payment System; Correction (pg. 32088)
08/15/90	Waiver of Certain Membership Requirements for Certain Health Maintenance Organizations (HMOs), and State Option for Disenrollment Restrictions for Certain HMOs Under Medicaid; Correction (pg. 33407)
08/17/90	Medicare Program; Payment for Outpatient Surgery at Eye Specialty Hospitals and Eye and Ear Specialty Hospitals (pg. 33697)
08/17/90	Medicaid Program; Eligibility of Qualified Severely Impaired Individuals Who Work (pg. 33700)
08/20/90	Medicare, Medicaid and CLIA Programs; Revisions for the Medicare, Medicaid and Clinical Laboratories Improvement Act of 1967 Programs; Correction (pg. 33907)
08/20/90	Clinical Laboratories Improvement Act Program; Granting and Withdrawal of Deeming Authority to Private Nonprofit Accreditation Organizations and State Licensure Agencies (pg. 33936)
08/21/90	Medicaid Program; Deadline for Submitting Moratorium State Plan Amendments; (pg. 34081)
08/22/90	Medicare, Medicaid and CLIA Programs; Regulations Implementing the Clinical Laboratory Improvement Amendments of 1988 (CLIA '88) (pg. 34289)
08/24/90	Medicare Program; Payment for Outpatient Surgery at Eye Specialty Hospitals and Eye and Specialty Hospitals; Correction (pg. 34797)

DATE	TITLE	DATE	TITLE
08/28/90	Medicare Programs; Physician Liability on Non-Assigned Claims (pg. 35142)		
08/30/90	Medicare Program; Exclusion of Certain Food Allergy Tests and Treatments from Medicare Coverage (pg. 35466)		
09/04/90	Medicare Program; Changes to the Inpatient Hospital Prospective Payment System and Fiscal Year 1991 Rates (pg. 35990)		
09/04/90	Medicare Program; Model Fee Schedule for Physicians Services (pg. 36178)		
09/05/90	Medicaid Program; MMIS System Performance Review Revisions (pg. 36319)		
09/06/90	Medicare Program; Geographical Classification Review Board; Procedures and Criteria (pg. 36754)		
09/07/90	Medicaid Program; Eligibility of Aliens for Medicaid (pg. 36813)		
09/13/90	Quarterly Listing of Program Issuances (pg. 37768)		
09/24/90	Medicare Program; Changes to the Inpatient Hospital Prospective Payment System and Fiscal Year 1991 Rates; Correction FR (pg. 39775)		
09/28/90	Criteria and Standards for Evaluating Intermediary and Carrier Performance (pg. 39730)		

CHAPTER VIII

Reports and Publications

Introduction

HCFA publishes a variety of reports and publications dealing with the Medicare program. Except where noted, single copies of the beneficiary publications listed in this section are usually available from local Social Security Administration offices during the year of issuance or by writing to:

Health Care Financing Administration
Office of Public Affairs (OPA)
Room 403-B Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

Placement on the mailing list for notification of all research and demonstration (R&D) reports as they are published, and single complimentary copies of publications, with the exception of the *HCF Review*, are available by written request from:

Health Care Financing Administration
Office of Research and Demonstrations (ORD)
Executive Secretariat
Room 2230 Oak Meadows Building
6325 Security Boulevard
Baltimore, Maryland 21207

Publications

Your Medicare Handbook (HCFA 10050). A comprehensive explanation of the Medicare program for Medicare beneficiaries.

1990 Medicare Program Highlights (Unnumbered, 1990). Leaflet describing changes in the Medicare program going into effect during calendar year 1990, including information on the repeal of the Medicare Catastrophic Coverage Act.

NOTICE: Medicare Publications Update for 1990 (HCFA 02154, 1990). Leaflet for use with previous year's publications, updating information to include repeal of catastrophic coverage.

Medicare Coverage of Kidney Dialysis and Kidney Transplant Services (HCFA 10128, 1990). Booklet describing Medicare coverage for end stage kidney disease patients.

Hospice Benefits Under Medicare (HCFA 02154, 1990). A pamphlet describing the special rules of coverage for care in a hospice program.

Guide to Health Insurance for People with Medicare (HCFA 02110, 1990). A consumer-oriented pamphlet for Medicare beneficiaries that discusses what Medicare pays and does not pay, types of private health insurance to supplement Medicare, and what to look for when shopping for private health insurance.

What You Should Know About Medicare (SSA-05-10043, January 1987). A pamphlet describing the basic aspects of Medicare including coverage, deductibles, coinsurance and eligibility requirements.

Medicare and Employer Health Plans (HCFA 02150, 1990). This pamphlet explains the law which requires employers to offer employed Medicare beneficiaries and their spouses age 65 or older the same health insurance plan that they offer to their younger employees and spouses.

Medicare and Prepayment Plans (HCFA 02143, 1990). Leaflet describing Medicare benefits available through health maintenance organizations and other prepayment plans.

Your Hospital Stay Under Medicare's Prospective Payment System (PPS) (HCFA 02163, 1989). A pamphlet describing the PPS, Diagnosis Related Groups and Peer Review Organizations.

Thinking of Having Surgery? Think About Getting A Second Opinion (HCFA 02114, 1990). A brochure addressing the advisability of seeking a second medical opinion before agreeing to any non-emergency surgery. It outlines questions a beneficiary should ask, when to get a second opinion, how to find a specialist to give a second opinion, and how to pay for a second opinion.

Medicare and You (unnumbered, 1990). Cartoon booklet explaining what Medicare is, what it covers and pays, and how to qualify for Medicare.

Medicare and Medicaid (There is a Difference!) (unnumbered, 1990). Cartoon booklet explaining the difference between Medicare and Medicaid.

Financing Health Care for People with AIDS (HCFA 02193, 1990). Booklet describing Medicare and Medicaid benefits paid for people with Acquired Immune Deficiency Syndrome (AIDS), including funds paid and number of persons covered.

Medicare Annual Report to Congress - 1987 (unnumbered, 1990). Congressionally mandated report of Medicare operations and administration for FY 1987.

Survey of State Medicaid Coverage of AIDS-Related Drugs (unnumbered, 1990). Booklet.

Reports

A series of publications covering research and demonstration activities and providing statistical information on the Medicare and Medicaid programs were part of a dissemination effort to reach interested user groups and to provide research results for policymakers and health professionals. These are:

National Medical Care Utilization and Expenditure Survey Reports – Reports on the survey findings, including information on access to and use of medical care, health and demographic characteristics of persons and families, and the sources and costs of services.

Health Care Financing Special Reports – Reports on single themes, providing comprehensive coverage of an important issue in health care financing.

Status Report: Research and Demonstrations in Health Care Financing – Provides basic information in a brief format on the approximately 300 intramural and extramural projects conducted by HCFA/ORD to examine program expenditures as they relate to reimbursement, coverage, eligibility and management alternatives under Medicare and Medicaid.

Health Care Financing Project Reports – Includes brief reports on individual research and demonstration projects that provide an overview of the project and major findings or results and include information on obtaining related publications.

Health Care Financing Review (Quarterly Journal Plus Annual Supplement) HCFA's quarterly research journal reports findings related to health care financing and delivery. Includes trends data that highlight economic developments in the health care sector and announcements of new HCFA research publications and projects. The HCF Review is available on a subscription basis ($13.00 per year) from:

Superintendent of Documents
U.S. Government Printing Office
Washington, D.C. 20402

Additional information on the research publications program and the availability of various reports may be obtained from:

ORD Publications and Information Resources Branch
Room 1-A-9
Oak Meadows Building
6325 Security Boulevard
Baltimore, Maryland 21207.

Final reports from completed extramural projects funded by HCFA are available for a fee by writing or phoning:

National Technical Information Services (NTIS)
Document Sales
5285 Port Royal Road
Springfield, Virginia 22161
(703) 487-4650 ***(Document Sales)***
(703) 487-5600 ***(General Information)***

Chapter IX

Report on Medicare Validation Surveys of Hospitals Accredited by the Joint Commission on Accreditation of Healthcare Organizations

(Joint Commission) FISCAL YEAR 1990

Introductions/Statutory Background

Section 1875 of the Social Security Act (the Act) requires the Secretary of the Department of Health and Human Services (DHHS) to validate the accreditation process of the Joint Commission on a continuous basis. This section also requires the Secretary of DHHS to submit an annual report to Congress on the findings of the validation process. The purpose of the validation program is to determine whether the Joint Commission's accreditation process provides reasonable assurance that accredited hospitals comply with the Medicare requirements as described in section 1865 of the Act.

Each year, the Health Care Financing Administration (HCFA) selects a statistical sample from the approximately 5,200 accredited hospitals for validation surveys. Validation surveys are also conducted in response to substantial allegations of the existence of a significant deficiency or deficiencies which would, if present, adversely affect the health and safety of patients.

Validation surveys are conducted by the Medicare State survey agencies (SAs) as authorized by section 1864(c) of the Act. During FY 1990, the SAs conducted 194 sample validation surveys and investigated 695 complaints which led to 35 full allegation surveys. These numbers do not include investigations of alleged violations of section 1867 of the Act (Examination and Treatment for Emergency Medical Conditions and Women in Labor). This report analyzes the findings from the validation and allegation surveys.

Accreditation Process

The Joint Commission survey team is composed of a physician, a registered nurse, a hospital administrator trained in the evaluation of the Life Safety Code (LSC) requirement, and a medical technologist. The medical technologist may not always be present on the survey as the Joint Commission accepts laboratory accreditation by the College of American Pathologists (CAP). Approximately 46 percent of the Joint Commission hospitals have laboratories accredited by CAP.

Although the Joint Commission's requirements are comparable to the Medicare Conditions of Participation (CoPs), there are numerous differences in the specific requirements. The format of the Joint Commission's standards and the survey report form they use to assess compliance are far more detailed than HCFA's.

The Joint Commission's accreditation survey assesses a hospital's compliance with the Joint Commission's standards. After the completion of the onsite survey, the Joint Commission makes an accreditation decision. The accreditation decisions are as follows: Accreditation, Accreditation with Type I or Type II recommendations, Conditional Ac-

creditation, or, in cases where a hospital fails to achieve substantial overall compliance, no accreditation.

Accreditation means that the hospital meets all of the Joint Commission standards and requirements. When the need for improvement exists, Type I recommendations are assigned. All Type I recommendations are monitored through a written progress report sent to the Joint Commission or through an on-site focused survey. Type I recommendations should receive the highest priority in the hospital's plans for improvement. Type II recommendations are supplementary or consultative in nature and do not affect the accreditation decision.

In 1989, the Joint Commission created a new "conditional accreditation" category as a possible survey outcome. Conditional accreditation procedures became effective for accreditation surveys conducted on or after July 1, 1989. The conditional accreditation decision is applicable to any hospital that has numerous Type I recommendations which require close monitoring and, without correction, may subject the hospital to a non-accreditation decision. The conditional accreditation procedures are designed to prompt these marginal hospitals to expedite efforts to improve performance.

In CY 1990, the Joint Commission made accreditation decisions for 1,822 hospitals.

Table 6

JOINT COMMISSION ACCREDITATION DECISIONS (SURVEYS CONDUCTED IN CY 1990)

TYPE OF DECISION	NUMBER OF HOSPITALS	PERCENTAGE
Accreditation w/o Type I recommendation	226	12.4
Accreditation with written progress report (WPR) Type I recommendations	526	28.9
Accreditation with follow-up visit Type I recommendations	255	*14.0
Accreditation with WPR and follow-up visit Type I recommendations	721	39.6
Conditional accreditation	**73	4.0
Decision to deny accreditation (Successful appeal)	3	.1
Denial of accreditation (in appeal process)	2	.1
Denial of accreditation (Final)	16	.8
Total	**1,822**	**100.0**

*The distribution of these accreditation decisions was determined by extrapolation based on a 6.6 percent random sample of accreditation decisions with Type I recommendations.

**There were 81 conditional accreditation decisions; eight of these resulted in a decision to deny accreditation (six of which are included in "Decision to Deny Accreditation (Final)" below and two are still under appeal); the remaining 73 decisions converted upon follow up survey to 38 accreditation w/o Type I recommendations and 35 accreditation w/Type I recommendations.

This number includes decisions on some hospitals that had accreditation surveys completed the latter part of CY 1989. Table 6 lists the types of accreditation decisions made by the Joint Commission and the number and percentage of hospitals receiving those decisions.

Validation and Alligation Process

1. Medicare Survey Process

The accredited hospitals are surveyed by the SAs using the Medicare CoPs for hospitals. In the case of a hospital selected for a sample validation survey, the SAs are requested to schedule their surveys within 60 days after the Joint Commission accreditation survey. This allows HCFA to evaluate the ability of the Joint Commission to identify deficiencies similar to those identified by the SAs.

Instructions to the SAs require that the survey be conducted on successive days in an objective manner without reference to accreditation findings. The validation team is not furnished a copy of the accreditation report and is told not to inquire about the accreditation survey findings.

The composition of the SA teams varies from State to State. Most of the States use a multidisciplinary team with representation from professional nursing, dietary, pharmacy, medical records, hospital administration and laboratory science specialties. Some States have physicians who act as consultants to members of the team. A few of the smaller States use generalists survey personnel only, with specialist staff available for consultation. The LSC survey is a separate survey conducted after the general health and safety survey is completed. Most States use fire safety professionals (e.g., fire marshals) to determine the extent of compliance with provisions of the LSC of the National Fire Protection Association (NFPA).

The survey process uses the "deficiency" as the primary measure of hospital quality of care. There are three deficiency severity levels. The condition level is the most severe. This level indicates the facility is seriously limited in its capacity to furnish an adequate level of quality of care. Standard level deficiencies are somewhat less severe. Elements, also called factors, are the least severe. While an institution may fail to comply with one or more of the subsidiary standards or elements during any given survey, it cannot participate in the Medicare program unless it meets each and every condition level requirement.

If an accredited hospital is found to have condition level deficiencies, it is no longer deemed to meet the CoPs. The hospital then becomes subject to SA surveillance under the same procedures applied to nonaccredited hospitals. Should the hospital not correct its deficiencies in accordance with an acceptable plan, the hospital is terminated from the Medicare program. When HCFA determines that the hospital no longer has condition level deficiencies, SA monitoring of the institution is discontinued, and the hospital is again deemed to meet the Medicare CoPs by virtue of its accreditation, but the Joint Commission is responsible for ensuring that the deficiencies are corrected.

2. Selection Basis

For sample validation surveys, HCFA selects a statistical sample from the Joint Commission's schedule of hospital accreditation surveys. The stratified random sample reflects the urban-rural mix and the range of sizes of participating hospitals. This permits HCFA to apply the findings to the universe of accredited hospitals. In an effort to increase the value of the analysis, the number of sample validation surveys was increased from 155 in FY 1989 to 194 in FY 1990. The 194 hospitals in this study have an average total bed capacity of 192 beds, with a range of 15 to 1030 beds.

In addition to the sample surveys, an accredited hospital is also subject to a SA

survey when there is an allegation that conditions threaten the health and safety of patients. Based on the nature of the complaint, allegation surveys evaluate only those specified Medicare CoPs as authorized by HCFA's regional offices. If the SA finds a condition level deficiency, the hospital is no longer deemed to meet the Medicare CoPs and is placed under SA monitoring until the condition level deficiency is corrected. The hospital is then subject to a full survey of all the CoPs. As stated earlier, 695 complaint investigations were performed during FY 1990, and 35 hospitals were placed under SA monitoring.

3. Evaluation Methodology

This report contains an analysis of the deficiencies identified in the SA validation surveys and the Joint Commission accreditation surveys conducted during the 1990 reporting period. The Joint Commission's letters of recommendation and survey reports and the HCFA Statement of Deficiencies (HCFA Form-2567) were used to identify each hospital's deficiencies.

a. The Crosswalk

To evaluate the data, HCFA and the Joint Commission developed an extensive and detailed crosswalk which assigns a Federal data tag to each Joint Commission

Table 7

TYPES OF DEFICIENCIES

CONDITION	NUMBER OF POSSIBLE DEFICIENCES
Federal, State and local laws	5
Governing Body	35
Quality Assurance	9
Medical Staff	16
Nursing Services	17
Pharmaceutical Services	15
Radiology Services	15
Laboratory Services	36
Form HCFA-1557	232
Physical Environment	14
Life Safety Code	87
Medical Records	19
Food and Dietetic Services	9
Infection Control	7
Surgical Services	13
Anesthesia Services	12
Nuclear Medicine Services	15
Outpatient Services	5
Emergency Services	8
Rehabilitation Services	5
Respiratory Care Services	8

1990 standard that is comparable to a Federal requirement. Strict comparability of these findings is limited because, overall, Joint Commission requirements are much more detailed than the Medicare conditions of participation.

b. Data Elements

This report examines deficiency data for 19 of the 20 Medicare CoPs. The Utilization Review condition was not surveyed by the SAs because the accredited hospitals are all subject to binding review by their State Peer Review Organizations (PROs). The Medicare utilization review requirements are considered satisfied when a PRO has assumed binding review for the hospital.

Survey findings were analyzed in terms of the number, nature, and types of requirements found out of compliance (deficiencies). The number of deficiencies refers to the total number of health and safety and LSC deficiencies cited in the sample validation hospitals. There are a maximum of 263 health and safety requirements, 232 additional laboratory requirements contained in Form HCFA-1557, and 87 LSC requirements per survey. A comparative analysis of the laboratory survey for the 232 additional laboratory requirements for FY 1990 was not performed because under the Clinical Laboratory Improvement Amendments of 1988 (CLIA 88), laboratory certification is now a separate program. The laboratory findings for FY 1990 now have no bearing on the decision to recognize "deemed status" because those requirements are no longer in effect.

The nature of the deficiencies reflects the level of severity. The severity levels in this report are the condition level, the standard level and the element level. There are 19 conditions, 57 standards, and 187 general health and safety elements.

The type of deficiencies refers to the number of health and safety deficiencies cited in the hospitals for each of the 19 Medicare CoPs. Both the number and type contain all deficiencies at the condition, standard and element level.

Table 7 shows the total number of possible deficiencies for each Medicare CoP.

c. Statistical Tests

Parametric statistical procedures were used to test for differences and association. Parametric statistical procedures assume the data are ordered by magnitude and have equal intervals and are normally distributed (i.e., a bell- shaped curve). The deficiencies were totalled and tested to verify that they are normally distributed. A t-test, Pearson correlation coefficient, and a coefficient of determination were calculated for the number, nature and type of deficiencies. An observed significance level of 0.05 was used throughout the analysis. These tests were used to explore the hypothesis that the deficiencies found during SA validation surveys are different than those found during Joint Commission accreditation surveys. To do this, a null hypothesis was constructed. For this report, the null hypothesis is the following: There is no difference in the deficiencies found during Joint Commission accreditation surveys and SA validation surveys. If the data disprove the null hypothesis by showing that the observed significance level is very small, then one can be reasonably comfortable that the data support the hypothesis. Of particular interest are differences at the condition level, since that could indicate problems with survey comparability.

FY 1990 Analysis

1. Sample Validation Surveys - Number of Deficiencies

For the FY 1990 reporting period, the SAs conducted 194 sample validation surveys. Appendix A lists each hospital in the sample, the hospital location and number of beds, the

Joint Commission accreditation decision and the Medicare CoPs found out of compliance during SA validation surveys. Some of the FY 1990 sampled hospitals were out of compliance with LSC. Life Safety Code appears in Appendix A with the assumption that the condition of Physical Environment was out-of-compliance due to the LSC problems.

Although the LSC is labeled a "standard" level deficiency under the CoP Physical Environment, if the LSC is found out of compliance, the Physical Environment is considered out of compliance. If Physical Environment is listed in Appendix A, this means requirements other than LSC led to the condition level deficiency. If Physical Environment and LSC are listed as out of compliance, LSC was not the only problem that led to the CoP Physical Environment being out of compliance.

Appendix B shows the numbers of conditions, standards, elements and LSC deficiencies identified during each survey. Appendix C shows that approximately 25.8 percent (50 hospitals) failed to comply with the Medicare CoPs and were placed under SA monitoring. Appendix C also compares the FY 1990 sample validation surveys to the FY 1989 sample and all previous report periods. The percentage of hospitals found out of compliance at the condition level decreased from FY 1989 to FY 1990 (29.0 percent to 25.8 percent). This is much less than all previous report periods where 48 percent of the hospitals were found out of compliance at the condition level.

None of the 50 hospitals found out of compliance with the CoPs were terminated from participation in the Medicare program. They were all able to correct their deficiencies prior to the termination date.

Table 8 illustrates that the Joint Commission identified 22 percent more general health and safety deficiencies than the SAs (2541 versus 2076). However, the SAs identified twice as many (1325 versus 699) LSC deficiencies than did the Joint Commission during the sample validation surveys. Overall, the SAs identified virtually the same number of total deficiencies (health and safety plus life safety code) as did the Joint Commission (3401 versus 3240).

Appendix D shows the frequency of unmet Medicare CoPs in hospitals for FY 1990 compared to FY 1989. The conditions most frequently cited by the SAs in FY 1990 were Physical Environment (12 hospitals/6.2 percent), Quality Assurance (10 hospitals/ 5.2 percent), Infection Control (10 hospitals/5.2 percent) and Laboratory Services (8 hospitals/ 4.1 percent). For FY 1989, the conditions most frequently cited were Physical Environment (17 hospitals/11.0 percent), Quality Assurance (17 hospitals/ 11.0 percent), Laboratory Services (12 hospitals/7.7 percent), and Governing Body (6 hospitals/3.9 percent).

Appendix E is a comparison of condition level deficiencies for the FY 1990 SA validation surveys and the Joint Commission accreditation surveys. The conditions cited most frequently by the Joint Commission were

Table 8

NUMBER OF TOTAL DEFICIENCIES BY SURVEY TYPE

	ACCREDITATION	VALIDATION
Health & Safety	2541	2076
Life Safety Code	699	1325
Total Deficiencies	**3240**	**3401**

Table 9

T-TEST OF TOTAL DEFICIENCIES

	VALUE	PROBABILITY
Health & Safety	2.7067	0.0074
Life Safety Code	-4.5087	0.0000

Quality Assurance (27 hospitals/13.9 percent), Infection Control (19 hospitals/9.8 percent) and Physical Environment (11 hospitals/5.7 percent).

A t-test was used to test the null hypothesis that there is no difference in the total number of deficiencies found during Joint Commission accreditation surveys and SA validation surveys. The results of the t-test can be found in Table 9. The null hypothesis could be rejected at the 0.05 significance level. The data indicate that there was a significant difference in the aggregate number of health and safety deficiencies between the validation and accreditation surveys with the Joint Commission identifying more in terms of total numbers of general health and safety deficiencies (conditions, standards and elements combined). Also, there was a significant difference in the total number of LSC deficiencies identified, with the Joint Commission identifying far fewer than would occur by chance alone.

The strength of the association for the difference in the total number of health and safety deficiencies and the differences in the total number of LSC deficiencies found between the two survey processes was tested by generating a Pearson Correlation Coefficient statistic. The results are in Table 10.

Table 10

PEARSON CORRELATION COEFFICIENT OF TOTAL DEFICIENCIES

	VALUE	PROBABILITY
Health & Safety	0.13648	0.0071
Life Safety Code	0.22367	0.0001

There was a small degree of association (-0.13648) between the survey type and the total number of health and safety deficiencies. This statistic is significant at the 0.0071 level. There was a small degree of association (0.22367) between survey type and the number of LSC deficiencies. This statistic is significant at the 0.0001 level.

To determine the proportion of the variances in the number of health and safety deficiencies and number of LSC deficiencies that is explained by survey type, a coefficient of determination was calculated by squaring the Pearson Correlation Coefficient. The results are in Table 11.

Table 11

COEFFICIENTS OF DETERMINATION

	VALUE
Health & Safety	0.02
Life Safety Code	0.05

Table 12

TOTAL DEFICIENCIES FOR EACH SEVERITY LEVEL BY SURVEY TYPE

	ACCREDITATION	VALIDATION
Condition	73	59
Standard	764	421
Element	1704	1596
Total	**2541**	**2076**

A value of 0.02 was obtained for the number of health and safety deficiencies. This figure indicates that only 2 percent of the total number of health and safety deficiencies may be explained by survey type. This suggests that 98 percent of the greater number of total health and safety deficiencies identified by the Joint Commission may be due to random error (e.g., individual surveyors, survey agency policies and procedures, hospital characteristics) rather than by survey type. A value of 0.05 was obtained for the total number of LSC deficiencies. This figure indicates that approximately 5 percent of the large number of LSC deficiencies cited by the SAs may be explained by survey type. This suggests that 95 percent of the greater number of LSC deficiencies identified by the SAs may be due to random error rather than by survey type.

2. Sample Validation Findings - Nature of the Deficiencies

The total number of deficiencies for the three severity levels (conditions, standards and elements) are identified in Table 12. The Joint Commission and SAs cited approximately the same number of condition level deficiencies (73 vs 59) and element level deficiencies (1704 vs 1596). Standard level deficiencies were significantly different (764 vs 421).

A t-test was used to test the null hypothesis that there is no difference in the nature of the deficiencies found during Joint Commission accreditation surveys and SA validation surveys. The results of the t-test on total deficiencies for each severity level are found in Table 13. At the condition level and element level, the data indicate that the null hypothesis could not be rejected; that is, there was no significant difference in the number of conditions and elements found deficient in the validation and accreditation surveys. However, at the standard level, the null hypothesis was rejected. The data for standard level deficiencies revealed a significant difference in the number of standard deficiencies identified.

The strength of the association for the standard level was tested by generating a Pearson Correlation statistic. There was a significant, but low, association (value - 0.36247, probability 0.0001). To determine the proportion of the variance in the number of standard level deficiencies explained by survey type, a coefficient of determination

Table 13

T-TEST OF DEFICIENCY SEVERITY BY SURVEY TYPE

	VALUE	PROBABILITY
Conditions	0.9859	0.3254
Standards	7.6411	0.0000
Elements	0.8236	0.4112

Table 14

TOTAL DEFICIENCIES (CONDITIONS, STANDARDS, ELEMENTS) FOR EACH DEFICIENCY TYPE CATEGORY BY SURVEY TYPE

	ACCREDITATION	VALIDATION
Laws	84	25
Governing Body	205	109
Quality Assurance	671	167
Medical Staff	331	120
Nursing Services	273	228
Medical Records	156	277
Pharmaceutical	74	217
Radiologic Services	62	52
Laboratory Services	83	172
Food & Dietetic	40	127
Physical Environment	181	184
Infection Control	128	87
Surgical Services	63	91
Anesthesia Services	15	76
Nuclear Medicine	15	18
Outpatient Services	21	16
Emergency Services	12	22
Rehabilitation	41	30
Respiratory	13	55

was calculated. A value of 0.13 was obtained for standard level of severity deficiencies. This figure indicates that approximately 13 percent of the large number of standard level deficiencies cited by the Joint Commission may be explained by survey type. This suggests that 87 percent of the greater number of standard level deficiencies identified by the SAs may be due to random error (e.g., individual surveyors, survey agency policies and procedures, hospital characteristics) rather than by survey type.

3. Sample Validation Surveys - Type of Deficiencies

The total number of deficiencies for the 19 deficiency type categories by survey type for the 194 hospitals are found in Table 14. Validation surveys identified a larger number of deficiencies in the following deficiency type categories: Medical Records Services, Pharmaceutical Services, Laboratory Services, Food and Dietetic Services, Surgical Services, Anesthesia Services, Emergency Services and Respiratory Care Services.

The Joint Commission identified more deficiencies in the following deficiency type categories: Federal, State and local laws, Governing Body, Quality Assurance, Medical Staff, Nursing Services and Infection Control. The emphasis on quality assurance, medical staff, infection control and the governing body's responsibility for quality assurance is consistent with the Joint Commission's program emphasis in recent years.

The results of a t-test of deficiency types for the accreditation and validation surveys are found in Table 15. This test was used to explore the null hypothesis that there is no difference in the types of deficiencies found during Joint Commission accreditation surveys and SA validation surveys. The null hypothesis was accepted for most of the deficiency type categories, thus indicating the

Table 15

T-TEST OF DEFICIENCY TYPES

	VALUE	PROBABILITY
Laws	1.0039	0.3167
Governing Body	-1.4179	0.1578
Quality Assurance	2.9640	0.0034
Medical Staff	-0.5784	0.5637
Nursing Services	0.5784	0.5637
Medical Records	0.0000	0.0000
Pharmaceutical	-1.0039	0.3167
Radiologic Services	*	*
Laboratory Services	-2.6879	0.0078
Food & Dietetic	0.0000	1.0000
Physical Environment	-0.2144	0.8304
Infection Control	1.7397	0.0835
Surgical Services	0.0000	1.0000
Anesthesia Services	1.0000	0.3186
Nuclear Medicine	1.4179	0.1578
Outpatient Services	0.0000	1.0000
Emergency Services	0.0000	1.0000
Rehabilitation	1.0000	0.3186
Respiratory	-2.2596	0.0250

*Values are the same for both survey types (0.0 and 0.0).

Joint Commission and SAs found the same deficiency types. The data indicate significant differences for the accreditation survey and validation survey findings in only four deficiency type categories—Quality Assurance, Medical Records Services, Laboratory Services and Respiratory Care Services.

The strength of the association between survey type (accreditation or validation) and the types of deficiencies cited more frequently in the validation surveys were tested by generating a Pearson Correlation Coefficient statistic. Those results can be found in Table16.

Table 11

PEARSON CORRELATION COEFFICIENT OF DEFICIENCY TYPES CITED MORE FREQUENTLY DURING SA VALIDATION SURVEYS BY SURVEY TYPE

VALUE	PROBABILITY
Medical Records	0.20710	0.0001
Pharmaceutical Services	0.27117	0.0001
Laboratory Services	0.16061	0.0015
Food and Dietetic Services	0.21890	0.0001
Surgical Services	0.09789	0.0540
Anesthesia Services	0.23775	0.0001
Emergency Services	0.06499	0.2015
Respiratory Services	0.22465	0.0001

Table 16

COEFFICIENTS OF DETERMINATION

	VALUE
Medical Records	0.04
Pharmaceutical Services	0.07
Laboratory Services	0.02
Food and Dietetic Services	0.04
Surgical Services	0.01
Anesthesia Services	0.06
Emergency Services	0.00
Respiratory Services	0.05

There are statistically significant relationships between survey type and the identification of these deficiency type categories. The associations, however, are low. So survey type is not a great predictor of the dependent variable, e.g., Medical Records. For Medical Records, approximately 20 percent of the deficiencies found by surveyors are "explained" by survey type. This is not a strong relationship.

A Coefficient of Determination was calculated for each of the eight deficiency types to determine the proportion of the variance in the deficiencies explained be survey type. Those results are found in Table 17.

Between a fraction of a percent and 7 percent of the greater number of deficiencies cited in the validation surveys are explained by survey type. This suggests that the variation in the type of deficiencies may be due to random error (e.g., surveyor, survey agency and facility characteristics) rather than to the survey type.

4. Allegation Survey Findings

During FY 1990, there were 35 full allegation surveys conducted (Appendix F). Results of investigations into allegations showed that in the 35 hospitals placed under SA surveillance, the most frequently occurring deficient conditions were Quality Assurance (37 percent), Physical Environment (26 percent), Nursing Services (23 percent), Laboratory Services (20 percent) and Governing Body (7 percent) (Appendix G). From FY 1989 to FY 1990, the percentage of hospitals found out of compliance with the Medicare CoPs and LSC was similar—2 percent in FY 1989 and 3 percent in FY 1990. Ninety-one percent (32 of 35 hospitals) were found out of compliance with the Medicare CoPs excluding the LSC, 6 percent (2 of 35 hospitals) were found out of compliance with the LSC only, and 3 percent (1 of 35 hospitals) were found out of compliance with at least one Medicare CoPs and the LSC (Appendix H).

Discussion

1. Number of Deficiencies

a. General health and safety deficiencies

On total number of deficiencies (conditions + standards + elements), the results of the t-test showed a significant difference between the number of general health and safety deficiencies and allowed rejection of the null hypothesis. Thus, the hypothesis that there are differences in the number of total health and safety deficiencies cited by the Joint Commission and SAs was accepted.

b. Life Safety Code

The LSC of the NFPA, a consensus standard adopted by reference in Federal regulations, provides a reasonable level of safety

from fire and other emergencies. The LSC for fire safety has been one of the most difficult requirements to meet for both accredited and nonaccredited hospitals.

In comparing the LSC deficiencies from FY 1989 to FY 1990 for sample validation surveys alone, the percentage of hospitals with major LSC deficiencies cited in the sample validation hospitals increased slightly—11.0% (17 of 155 hospitals) in FY 1989 to 11.3% (22 of 194 hospitals) in FY 1990 (Appendix D). For all previous report periods (1974-1988), 36 percent (467 of 1281 hospitals) of the hospitals were found out of compliance with the LSC. (Appendix C). The decrease in LSC deficiencies in the past2 years (FY 1989 and FY 1990) compared to allprevious report periods may be attributed to ourapplication and enforcement of the Fire Safety Evaluation System (FSES). The FSES was developed by the National Institute of Standards and Technology to permit a health care facility to employ alternative measures for meeting the LSC requirements while providing an equivalent levelof fire safety. The FSES is now part of the LSC.

There was a significant difference in the number of LSC deficiencies identified by the SAs and the Joint Commission. The SAs identified 1,325 LSC violations and the Joint Commission 699 in FY 1990. The t-test on Table 9 showed that the SAs identified more than two times the total number of LSC deficiency tags than did the Joint Commission. Unfortunately, the crosswalk for the LSC portion of this report could not be considered valid because of systems difficulties at the Joint Commission. Therefore, HCFA cannot make a comparison of condition level deficiencies with comparable deficiencies based on Joint Commission findings. HCFA continues to work with the Joint Commission to reduce the discrepancy between the raw number of deficiencies identified by the SAs and the raw numbers found by the Joint Commission.

2. Nature of Deficiencies

Statistical tests indicated that the SAs cite condition level deficiencies about the same as the Joint Commission. In FY 1990, the CoPs most frequently found out of compliance for validation surveys were Physical Environment (12 hospitals), Quality Assurance (10 hospitals), Laboratory Services (12 hospitals), Infection Control (10 hospitals) and Radiologic Services (8 hospitals). These have been the most frequently cited COPs since 1987 when the Quality Assurance condition was introduced to the Medicare hospital CoPs.

For condition level severity health and safety requirements, the Joint Commission surveyors cited deficiencies about the same frequency; however, the Joint Commission does not take the same enforcement action as the SAs through its decisions; that is, nonaccreditation and conditional accreditation decisions were not rendered for all hospitals with condition level problems. Appendix C shows 50 hospitals out of compliance at the condition level. These hospitals were all placed on termination tracks but, as stated above, were able to correct their deficiencies prior to the termination dates. The Joint Commission rendered a variety of decisions for hospitals with condition level deficiencies: accreditation with Type I recommendations, conditional accreditation and nonaccreditation decisions.

Appendix A shows four hospitals for which the Joint Commission rendered a nonaccreditation decision and six hospitals for which the Joint Commission rendered a conditional accreditation decision.

3. Type of Deficiencies

Statistical tests revealed significant differences in only four deficiency type categories—Quality Assurance, Medical Record Services, Laboratory Services and Respiratory Care Services.

The Joint Commission identifies more deficiencies in Governing Body, Medical

Staff, Nursing Services, Quality Assurance and Infection Control than do the SAs. This reflects the Joint Commission's program emphasis in the past several years.

The SAs identify significantly more deficiencies in Medical Record Services, Pharmaceutical Services, Laboratory Services, Food and Dietetic Services, Surgical Services, Anesthesia Services, Emergency Services and Respiratory Care Services than the Joint Commission. Without access to CAP findings it is impossible to determine whether the SAs find greater numbers of Laboratory Services deficiencies. Also, as stated before, due to CLIA, the laboratory deficiencies identified were not analyzed in detail because laboratory conditions are now subject to a separate survey process. The larger number of pharmaceutical and dietetic deficiencies cited by the SAs probably reflects survey team composition, in that the SAs often use pharmacists and dietitians as consultants and surveyors.

4. Allegation Surveys

For allegation surveys, the data show a decrease in the percentage of hospitals found to have one or more conditions out of compliance as a result of allegation investigations. Of the 695 hospitals surveyed as the result of substantial allegations, 5 percent were not in compliance with one or more conditions of participation as compared to 10 percent from the last report period.

Conclusions and Recommendations

Our analysis of all aspects of the Joint Commission's performance based on validation and complaint surveys indicates that, in general, Joint Commission accreditation does, in fact, provide reasonable assurance that accredited hospitals meet Federal requirements. Our analysis also leads to some specificclusions about particular aspects of the Joint Commission's accreditation program as well as State agency survey operations and HCFA's continuing oversight of these programs

- The automated crosswalk of Medicare hospital health and safety requirements to Joint Commission standards has effectuated a more thorough analysis of accreditation survey and validation survey findings, although problems with the LSC requirements need to be resolved.
- Meeting quality assurance requirements is problematic for all hospitals.
- The Joint Commission enforces quality assurance and infection control requirements more vigorously than the SAs.
- SAs have more expertise and more vigorously enforce LSC requirements.
- The Joint Commission surveyors cited condition level deficiencies at about the same frequency as the SAs; however, the Joint Commission does not take enforcement action of the same magnitude as the SAs; that is, for the 50 hospitals found out of compliance at the condition level during validation surveys, all were given termination notices. The Joint Commission rendered a variety of decisions for hospitals with condition level deficiencies: accreditation with Type I recommendations, conditional accreditation and nonaccreditation decisions.

These conclusions lead to the following recommendations which we will pursue over future months:

- HCFA will continue to offer central office basic training and regional office training to SA surveyors as a method of improving the survey process.
- HCFA will be sending LSC staff to the Joint Commission, with the expressed purpose of resolving the crosswalk and systems problems.
- Observation surveys of the Joint Commission accreditation process should be conducted to better assess how the Joint

Commission evaluates facilities for compliance with the LSC and all Medicare hospital health and safety requirements.

- HCFA should observe Joint Commission surveyor training programs to provide insight into the Joint Commission decision process.
- The Joint Commission should continue to refine its decision making process to assure timely followup on problems identified through its survey process.

APPENDIX A

FY 1990 SAMPLE VALIDATION SURVEYS
JOINT COMMISSION ACCREDITATION AND HCFA CERTIFICATION DECISIONS
194 HOSPITALS

HOSPITAL	NUMBER OF BEDS	JOINT COMMISSION ACCREDITATION DECISION	HCFA CERTIFICATION DECISION	MEDICARE CONDITIONS NOT MET
REGION I				
07-0029 Bristol Hospital Bristol, CT	250	Accreditation w/Type I Recom.	not met	PE, LSC
07-0008 Johnson Memorial Stafford Springs, CT	78	Accreditation w/Type I Recom.	not met	I, S
07-4008 Natchaug Hospital Willimantic, CT	60	Accreditation w/Type I Recom.	not met	I
20-0055 Calais Regional Calais, ME	49	Accreditation w/Type I Recom.	met	—
20-0024 Central ME Medical Lewiston, ME	250	Accreditation w/Type I Recom.	met	—
22-4027 AMI Pembroke Pembroke, MA	25	Accreditation w/Type I Recom.	met	—
22-3027 Braintree Hospital Braintree, MA	154	Accreditation	met	—
22-0094 Leominster Hospital Leominster, MA	117	Accreditation w/Type I Recom.	met	—
22-0050 Mary Lane Hospital Ware, MA	69	Accreditation w/Type I Recom.	met	—
22-0022 St Annes Hospital Fall River, MA	182	Accreditation w/Type I Recom.	not met	I

* "Met" indicates that the hospital met all Conditions. Standard and element level deficiencies may have been found.
** "Not Met" indicates that the hospital was out of compliance with one or more Conditions.

Letter Code for Conditions Out of Compliance

F - Federal, State, and local laws
G - Governing Body
Q - Quality Assurance
M - Medical Staff
N - Nursing Services
P - Pharmaceutical Services
R - Radiologic Services
L - Laboratory Services
PE - Physical Environment
MR - Medical Record Services
FD - Food and Dietetic Services
I - Infection Control
S - Surgical Services
LSC - Life Safety Code
A - Anesthesia Services
NM - Nuclear Medicine
O - Outpatient Services
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194 HOSPITALS

HOSPITAL	NUMBER OF BEDS	JOINT COMMISSION ACCREDITATION DECISION	HCFA CERTIFICATION DECISION	MEDICARE CONDITIONS NOT MET
22-2000 Youville Rehab Cambridge, MA	305	Accreditation w/Type I Recom.	met	—
30-4002 Lake Shore Hospital Manchester, NH	90	Accreditation w/Type I Recom.	met	—
41-4000 Butler Hospital Providence, RI	117	Accreditation w/Type I Recom.	met	—
41-0011 Landmark Medical Ctr Woonsocket, RI	315	Accreditation w/Type I Recom.	met	—
47-0004 Gifford Memorial Randolph, VT	53	Accreditation w/Type I Recom.	met	—
REGION II				
31-0016 Christ Hospital Jersey City, NJ	367	Accreditation w/Type I Recom.	met	—
31-0008 Holy Name Hospital Teaneck, NJ	361	Accreditation w/Type I Recom.	met	—
31-0074 Jersey City Medical Ctr Jersey City, NJ	608	Accreditation w/Type I Recom.	met	—
31-0015 Morristown Memorial Morristown, NJ	541	Accreditation w/Type I Recom.	not met	Q
31-0088 William Kessler Memorial Hammonton, NJ	130	Accreditation w/Type I Recom.	met	—

* "Met" indicates that the hospital met all Conditions. Standard and element level deficiencies may have been found.
** "Not Met" indicates that the hospital was out of compliance with one or more Conditions.

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194 HOSPITALS

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33-4023 Benjamin Rush Center Syracuse, NY	107	Accreditation w/Type I Recom.	met	—
33-0036 Dobbs Ferry Hospital Dobbs Ferry, NY	50	Accreditation w/Type I Recom.	met	—
33-0164 Highland Hospital Rochester, NY	272	Accreditation w/Type I Recom.	not met	I
33-0075 Albert Lee Memorial Fulton, NY	67	Accreditation w/Type I Recom.	met	—
33-0152 Long Island Hospital Brooklyn, NY	567	Accreditation w/Type I Recom.	not met	PE, I
33-0279 Mercy Hospital Bullalo, NY	349	Accreditation w/Type I Recom.	met	—
33-0062 Schuyler Hospital Montour Falls, NY	49	Accreditation w/Type I Recom.	met	—
33-0122 Yonkers General Hospital Yonkers, NY	190	Accreditation w/Type I Recom.	met	—
REGION III				
08-0007 Beebe Medical Center Lewes, DE	150	Accreditation w/Type I Recom.	not met	LSC
09-0007 District of Columbia Gen Washington, DC	210	Accreditation w/Type I Recom.	not met	E, LSC

* "Met" indicates that the hospital met all Conditions. Standard and element level deficiencies may have been found.
** "Not Met" indicates that the hospital was out of compliance with one or more Conditions.

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194 HOSPITALS

HOSPITAL	NUMBER OF BEDS	JOINT COMMISSION ACCREDITATION DECISION	HCFA CERTIFICATION DECISION	MEDICARE CONDITIONS NOT MET
21-0009 Johns Hopkins Hospital Baltimore, MD	1,030	Accreditation w/Type I Recom.	met	—
21-0002 University of MD Baltimore, MD	785	Accreditation w/Type I Recom.	met	—
39-0179 Chester County Hospital West Chester, PA	175	Accreditation w/Type I Recom.	not met	PE, LSC
39-0200 Columbia Hospital Columbia, PA	61	Accreditation w/Type I Recom.	not met	PE, LSC
39-0110 Conemaugh Valley Memorial Johnstown, PA	346	Accreditation w/Type I Recom.	not met	PE, LSC
39-0080 Jeanes Hospital Philadelphia, PA	148	Accreditation w/Type I Recom.	not met	LSC
39-0071 Lock Haven Hospital Lock Haven, PA	91	Accreditation w/Type I Recom.	not met	LSC
39-0113 Meadville Medical Center Meadville, PA	236	Accreditation w/Type I Recom.	met	—
39-0055 Shadyside Hospital Pittsburg, PA	359	Accreditation w/Type I Recom.	not met	LSC
39-0009 St Vincent Health Center Erie, PA	466	Accreditation w/Type I Recom.	not met	PE

* "Met" indicates that the hospital met all Conditions. Standard and element level deficiencies may have been found.
** "Not Met" indicates that the hospital was out of compliance with one or more Conditions.

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194 HOSPITALS

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39-0084 Sunbury Community Hospital Sunbury, PA	105	Accreditation w/Type I Recom.	met	—
39-0122 Titusville Hospital Titusville, PA	64	Accreditation w/Type I Recom.	met	—
49-0101 Fair Oaks Hospital Fairfax, VA	160	Accreditation w/Type I Recom.	not met	PE, LSC
49-0023 Fauquier Hospital Warrenton, VA	121	Accreditation	met	—
49-0045 Prince William Hospital Manassa, VA	170	Accreditation w/Type I Recom.	met	—
49-0115 Twin County Comm. Hosp Galax, VA	149	Accreditation w/Type I Recom.	met	—
51-0071 Bluefield Regional Medical Bluefield, WV	265	Accreditation w/Type I Recom.	met	—
51-4008 HCA River Park Hospital Huntington, WV	174	Accreditation w/Type I Recom.	met	—
51-0061 Potomac Valley Hospital Keyser, WV	63	Accreditation w/Type I Recom.	met	—

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194 HOSPITALS

HOSPITAL	NUMBER OF BEDS	JOINT COMMISSION ACCREDITATION DECISION	HCFA CERTIFICATION DECISION	MEDICARE CONDITIONS NOT MET
Region IV				
01-0005 Boaz Albertville Medical Boaz, AL	150	Accreditation w/Type I Recom.	met	—
01-0097 Central AL Medical Center Wetumpka, AL	69	Nonaccreditation	met	—
01-0049 Humana Hospital Enterprise Enterprise, AL	135	Accreditation w/Type I Recom.	met	—
01-0083 South Baldwin Hospital Foley, AL	82	Accreditation w/Type I Recom.	not met	LSC
10-0239 Edward White Hospital Saint Peterburg, FL	167	Accreditation w/Type I Recom.	met	—
10-0019 Holmes Regional Medical Melbourne, FL	528	Accreditation w/Type I Recom.	met	—
10-0073 Holy Cross Hospital Fort Lauderdale, FL	597	Accreditation w/Type I Recom.	met	—
10-0229 Humana Hospital Daytona Daytona Beach, FL	214	Accreditation	met	—
10-0213 HCA L. W. Blake Hospital Bradenton, FL	383	Accreditation	met	—
10-4006 Palmview Hospital Lakeland, FL	66	Accreditation w/Type I Recom.	met	—

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10-0074 St Cloud Hospital St Cloud, FL	84	Accreditation w/Type I Recom.	met	—
10-0014 Fish Memorial Hospital New Smyrna Beach, FL	116	Accreditation w/Type I Recom.	met	—
10-0092 Wuesthoof Memorial Hosp Rockledge, FL	303	Accreditation w/Type I Recom.	met	—
11-0036 Memorial Medical Center Savannah, GA	475	Accreditation	not met	LSC
11-0032 Stephens County Hospital Toccoa, GA	99	Accreditation w/Type I Recom.	not met	Q, L
11-0011 Tanner Memorial Center Carrollton, GA	222	Accreditation w/Type I Recom.	met	—
11-0015 Tanner Medical Center Villia Rica, GA	54	Accreditation w/Type I Recom.	met	—
11-0028 University Hospital Augusta, GA	690	Conditional	not met	LSC
18-0103 Central Baptist Hospital Lexington, KY	383	Accreditation w/Type I Recom.	not met	Q, L, RC
18-0027 Murray-Calloway Murray, KY	176	Accreditation w/Type I Recom.	not met	Q, L, RC

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25-0082 Delta Medical Center Greenville, MS	268	Accreditation w/Type I Recom.	met	—
25-0129 Doctors Hospital Jackson, MS	162	Accreditation w/Type I Recom.	not met	PE, LSC
25-4003 Gulf Oaks Hospital Biloxi, MS	45	Accreditation w/Type I Recom.	met	—
25-0040 Singing River Hospital Pascagoula, MS	415	Accreditation	met	—
34-0038 Beaufort County Hospital Washington, NC	158	Accreditation w/Type I Recom.	met	—
34-0005 Charles A Cannon Memorial Banner Elk, NC	92	Accreditation w/Type I Recom.	met	—
34-0017 Margaret Pardee Hospital Hendersonville, NC	233	Accreditation w/Type I Recom.	met	—
34-0061 University of NC Hospital Chapel Hill, NC	609	Accreditation w/Type I Recom.	met	—
42-4008 Charter Rivers Hospital West Columbia, SC	78	Accreditation w/Type I Recom.	met	—
42-0040 Florence General Hospital Florence, SC	187	Accreditation w/Type I Recom.	met	—

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44-0132 Henry County General Hosp Paris, TN	142	Conditional	not met	Q
44-0051 McNairy County General Selmer, TN	86	Accreditation w/Type I Recom.	met	—
44-0050 Takoma Adventist Hospital Greeneville, TN	115	Accreditation w/Type I Recom.	not met	I
Region V				
14-0208 Christ Hospital Oak Lawn, IL	824	Accreditation w/Type I Recom.	not met	I
14-0074 Galena-Strauss Hospital Gelena, IL	29	Accreditation w/Type I Recom.	met	—
14-0139 Illini Community Hospital Pittsfield, IL	59	Accreditation w/Type I Recom.	met	—
14-0036 Kewanee Hospital Kewanee, IL	101	Accreditation w/Type I Recom.	met	—
14-0112 Mason District Hospital Havana, IL	41	Accreditation w/Type I Recom.	met	—
14-0164 Memorial Hospital Carbondale, IL	141	Accreditation w/Type I Recom.	met	—
14-0117 Resurrection Medical Ctr Chicago, IL	454	Accreditation w/Type I Recom.	not met	I, LSC

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14-0052 St Anthony Health Center Alton, IL	244	Accreditation w/Type I Recom.	met	—
15-0077 Memorial Hospital of MI Michigan City, IN	102	Accreditation w/Type I Recom.	met	—
15-0134 North Clark Community Charlestown, IN	96	Accreditation w/Type I Recom.	met	—
15-0003 St Elizabeth Hospital Lafayette, IN	375	Accreditation w/Type I Recom.	met	—
15-0033 St Francis Hospital Beech Grove, IN	540	Accreditation w/Type I Recom.	met	—
15-0088 St Johns Health Care Anderson, IN	371	Accreditation w/Type I Recom.	met	—
15-0036 White County Memorial Monticello, IN	59	Accreditation w/Type I Recom.	not met	LSC
23-0235 Caro Community Hospital Caro, IM	50	Accreditation w/Type I Recom.	met	—
23-0124 Charlevoix Area Hospital Charlevoix, MI	44	Accreditation w/Type I Recom.	met	—
23-0153 Eaton Rapids Community Eaton Rapids, MI	41	Accreditation w/Type I Recom.	not met	I

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23-0053 Henry Ford Hospital Detroit, MI	903	Accreditation w/Type I Recom.	met	—
23-0270 Heritage Hospital Taylor, MI	271	Accreditation w/Type I Recom.	met	—
23-0189 Mid-MI Regional Medical Gladwin, MI	42	Accreditation w/Type I Recom.	met	—
23-0062 Paul Oliver Memorial Frankfort, MI	26	Conditional	not met	PE
23-0147 Samaritan Health Center Detroit, MI	375	Accreditation w/Type I Recom.	met	—
24-0008 St Elizabeth Hospital Wabasha, MN	31	Accreditation w/Type I Recom.	not met	Q, L
24-4004 St Peter Regional St Peter, MN	176	Accreditation w/Type I Recom.	met	—
24-0009 Tracy Municipal Hospital Tracy, MN	37	Conditional	not met	L
36-0116 Brown County Hospital Georgetown, OH	146	Accreditation w/Type I Recom.	met	—
36-0074 Flower Hospital Sylvania, OH	533	Accreditation w/Type I Recom.	met	—

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36-0039 Good Samaritan Medical Zanesville, OH	415	Accreditation	met	—
36-0176 Hardin Memorial Hospital Kenton, OH	121	Accreditation w/Type I Recom.	met	—
36-0172 Lorain Community Hospital Lorain. OH	293	Accreditation w/Type I Recom.	met	—
36-0197 Mary Rutan Hospital Bellefontaine, OH	120	Accreditation	met	—
36-0050 Oak Hill Community Med Oak Hill, OH	45	Accreditation w/Type I Recom.	met	—
36-0148 Joel Pomerene Memorial Millersburg, OH	55	Accreditation w/Type I Recom.	met	—
36-0049 St Alexis Hospital Cleveland, OH	337	Accreditation w/Type I Recom.	met	—
52-0012 Clintonville Community Clintonville, WI	54	Accreditation w/Type I Recom.	met	—
52-4031 Fox Valley Hospital Green Bay, WI	80	Accreditation w/Type I Recom.	met	—
52-0032 Memorial Hosp. of Iowa Dodgeville, WI	40	Accreditation	not met	PE, LSC

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52-0134 Prairie Du Chien Memorial Prairie Du Chien, WI	49	Accreditation	met	—
Region VI				
04-0051 Drew Memorial Hosp Monticello, AR	50	Nonaccreditation	not met	G, Q, N, MR
19-0164 Bryd Memorial Hospital Leesville, LA	70	Accreditation w/Type I Recom.	not met	L
19-0116 Morehouse General Hosp Bastrop, LA	119	Accreditation w/Type I Recom.	not met	L
19-4013 Parkland Hospital Baton Rouge, LA	216	Accreditation w/Type I Recom.	met	—
19-0124 Pendleton Memorial New Orleans, LA	299	Accreditation w/Type I Recom.	met	—
19-0040 Slidell General Hospital Slidell, LA	182	Accreditation w/Type I Recom.	met	—
32-4006 Sun Crest Hospital Farmington, NM	54	Accreditation w/Type I Recom.	met	—
37-0029 Clinton Regional Clinton, OK	75	Accreditation w/Type I Recom.	met	—
37-0056 Commanche Memorial Lawton, OK	283	Accreditation w/Type I Recom.	not met	PE, LSC

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37-0156 Pauls Valley General Pauls Valley, OK	70	Accreditation w/Type I Recom.	met	—
37-4012 Brookhaven Hospital Tulsa, OK	40	Accreditation w/Type I Recom.	met	—
45-0124 Brackenridge Hospital Austin, TX	264	Accreditation w/Type I Recom.	met	—
45-0259 Doctors Hospital East Loop Houston, TX	135	Accreditation	met	—
45-0716 Cypress Fairbanks Med Ctr Houston, TX	64	Accreditation w/Type I Recom.	met	—
45-4018 HCA Red River Hospital Wichita Fall, TX	47	Accreditation w/Type I Recom.	met	—
45-0580 Houston County Hospital Crookett, TX	65	Accreditation w/Type I Recom.	not met	P, RC
45-0755 Methodist Hospital Levelland, TX	61	Accreditation w/Type I Recom.	met	—
45-0652 Palo Duro Hospital Canyon, TX	49	Accreditation w/Type I Recom.	not met	M
45-3035 San Antonio Warm Springs San Antonio, TX	60	Accreditation	met	—

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45-0653 Scenic Mountain Medical Big Spring, TX	153	Accreditation w/Type I Recom.	met	—
45-0054 Scott & White Memorial Temple, TX	632	Accreditation w/Type I Recom.	not met	RC
45-0044 St Paul Medical Center Dallas, TX	420	Accreditation	met	—
45-0484 Woodland Height Medical Lufkin, TX	117	Accreditation w/Type I Recom.	not met	Q, P, RC
Region VII				
16-0117 Finley Hospital Dubuque, IA	158	Accreditation w/Type I Recom.	met	—
16-0114 Knoxville Community Hosp Knoxville,IA	49	Conditional	met	—
16-0032 Skiff Medical Center Newton, IA	49	Conditional	met	—
16-0020 St Josephs Mercy Hosp Centerville, IA	47	Accreditation w/Type I Recom.	met	—
17-0145 Coffeyville Regional Coffeyville, KS	124	Accreditation w/Type I Recom.	met	—
17-0137 Lawrence Memorial Hosp Lawrence, KS	190	Accreditation w/Type I Recom.	met	—

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17-0007 St Marys Health Center Emporia, KS	67	Accreditation w/Type I Recom.	met	—
26-0042 Bethesda General Hosp Saint Louis, MO	94	Accreditation w/Type I Recom.	met	—
26-0163 Farmington Regional Farmington, MO	130	Accreditation w/Type I Recom.	not met	L
26-0047 Memorial Community Hosp Jefferson City, MO	100	Accreditation w/Type I Recom.	met	—
26-0183 St Francis Medical Ctr Cage Girardeau, MO	246	Accreditation w/Type I Recom.	met	—
28-4002 Hastings Regional Center Hastings, NE	132	Accreditation w/Type I Recom.	met	—
28-0085 Lutheran Medical Center Omaha, NE	263	Accreditation w/Type I Recom.	met	—
28-0020 St Elizabeth Comm Lincoln, NE	208	Accreditation	met	—
Region VIII				
06-0101 Craig Hospital Englewood, CO	80	Accreditation	not met	F, PE, LSC
06-0065 Humana Mountain View Thornton, CO	200	Accreditation w/Type I Recom.	met	—

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06-0004 Platte Valley Medical Brighton, CO	58	Accreditation w/Type I Recom.	met	—
27-0002 Holy Rosary Hospital Miles City, MT	99	Accreditation w/Type I Recom.	met	—
27-0048 Glendive Medical Center Glendive, MT	46	Accreditation w/Type I Recom.	met	—
35-0043 Trinity Medical Center Minot, ND	251	Accreditation	met	—
35-0047 Unity Hospital Grafton, ND	48	Accreditation w/Type I Recom.	met	—
43-0011 Huron Regional Medical Huron, SD	98	Accreditation w/Type I Recom.	met	—
43-0012 Sacred Heart Hospital Yankton, SD	144	Accreditation w/Type I Recom.	met	—
46-0009 University of Utah Salt Lake City, UT	372	Accreditation w/Type I Recom.	met	—
46-4008 Wasatch Canyons Hospital Salt Lake City, UT	64	Accreditation	met	—
53-0008 Riverton Memorial Riverton, WY	70	Accreditation w/Type I Recom.	not met	Q, FD, I

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53-0023 Star Valley Hospital Afton, WY	15	Nonaccreditation	not met	O
Region IX				
03-4003 Tucson Psych Institute Tucson, AZ	62	Accreditation w/Type I Recom.	met	—
05-0219 Coast Plaza Medical Ctr Norwalk, CA	126	Accreditation w/Type I Recom.	met	—
05-0349 Corcoran District Hosp Corcoran, CA	32	Nonaccreditation	met	—
05-0158 Encino Hospital Encino, CA	181	Accreditation w/Type I Recom.	met	—
05-0225 Feather River Hospital Paradise, CA	109	Accreditation w/Type I Recom.	met	—
05-0189 George Mee Memorial Hosp King City, CA	42	Accreditation w/Type I Recom.	not met	LSC
05-0512 Kaiser Foundation Hosp Hayward, CA	193	Accreditation w/Type I Recom.	not met	LSC
05-4085 Los Altos Hospital Long Beach, CA	80	Accreditation w/Type I Recom.	met	—
05-0684 Menifee Valley Medical Sun City, CA	84	Accreditation w/Type I Recom.	met	—

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05-0115 Palomar Medical Center Escondido, CA	414	Accreditation w/Type I Recom.	met	—
05-0102 Parkview Community Hosp Riverside, CA	193	Accreditation w/Type I Recom.	met	—
05-0636 Pomerado Hospital Poway, CA	279	Accreditation w/Type I Recom.	met	—
05-0401 Washington Hospital Culver City, CA	99	Accreditation w/Type I Recom.	not met	G, Q, M, P
05-0594 Western Medical Anaheim Anaheim, CA	206	Accreditation w/Type I Recom.	not met	LSC
12-0014 Wilcox Memorial Hospital Lihue, HI	75	Accreditation w/Type I Recom.	met	—
Region X				
02-0027 Mt Edgecumbe Hospital Sitka, AK	78	Accreditation w/Type I Recom.	met	—
13-0022 Bingham Memorial Hosp Blackfoot, ID	54	Accreditation w/Type I Recom.	met	—
13-0026 Cassia Memorials Hospital Burley, ID	53	Accreditation w/Type I Recom.	met	—
38-4006 Pacific Gateway Hospital Portland, OR	66	Accreditation w/Type I Recom.	met	—

* "Met" indicates that the hospital met all Conditions. Standard and element level deficiencies may have been found.
** "Not Met" indicates that the hospital was out of compliance with one or more Conditions.

Letter Code for Conditions Out of Compliance

F - Federal, State, and local laws
G - Governing Body
Q - Quality Assurance
M - Medical Staff
N - Nursing Services
P - Pharmaceutical Services
R - Radiologic Services
L - Laboratory Services
PE - Physical Environment
MR - Medical Record Services
FD - Food and Dietetic Services
I - Infection Control
S - Surgical Services
LSC - Life Safety Code
A - Anesthesia Services
NM - Nuclear Medicine
O - Outpatient Services
E - Emergency Services
RS - Rehabilitation Services
RC - Respiratory Care

APPENDIX A

FY 1990 SAMPLE VALIDATION SURVEYS
JOINT COMMISSION ACCREDITATION AND HCFA CERTIFICATION DECISIONS
194 HOSPITALS

HOSPITAL	NUMBER OF BEDS	JOINT COMMISSION ACCREDITATION DECISION	HCFA CERTIFICATION DECISION	MEDICARE CONDITIONS NOT MET
38-0061 Providence Medical Ctr Portland, OR	483	Accreditation w/Type I Recom.	met	—
38-0056 Santiam Memorial Stayton, OR	40	Accreditation w/Type I Recom.	met	—
50-0015 Auburn General Hospital Auburn, WA	149	Accreditation w/Type I Recom.	met	—
50-0027 Swedish Hospital Seattle, WA	697	Accreditation w/Type I Recom.	met	—
50-0050 S. W. Washington Med Vancouver, WA	192	Accreditation w/Type I Recom.	met	—

* "Met" indicates that the hospital met all Conditions. Standard and element level deficiencies may have been found.
** "Not Met" indicates that the hospital was out of compliance with one or more Conditions.

Letter Code for Conditions Out of Compliance

F - Federal, State, and local laws
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S - Surgical Services
LSC - Life Safety Code
A - Anesthesia Services
NM - Nuclear Medicine
O - Outpatient Services
E - Emergency Services
RS - Rehabilitation Services
RC - Respiratory Care

APPENDIX B

FY 1990 SAMPLE VALIDATION SURVEYS DEFICIENCY FINDINGS

	JOINT COMMISSION ACCREDITATION DEFICIENCY FINDINGS					HCFA CERTIFICATION DEFICIENCY FINDINGS				
HOSPITAL	CONDITIONS	STANDARDS	ELEMENTS	LSC	TOTAL	CONDITIONS	STANDARDS	ELEMENTS	LSC	TOTAL
REGION I										
Bristol Hospital 07-0029	0	3	10	5	18	1	6	16	6	29
Johnson Memorial 07-0008	0	2	4	2	8	2	6	11	0	19
Natchaug Hospital 07-4008	1	2	12	3	18	1	4	20	4	29
Calais Regional 20-0055	1	5	14	12	32	0	0	0	0	0
Central ME Medical 20-0024	1	5	10	2	18	0	5	15	2	22
AMI Pembroke Hospital 22-4027	0	2	8	0	10	0	1	17	7	25
Braintree Hospital 22-3027	0	1	3	0	4	0	0	5	2	7
Leominster Hospital 22-0094	1	5	9	9	24	0	1	4	4	9
Mary Lane Hospital 22-0050	0	6	10	12	28	0	5	14	13	32
St Annes Hospital 22-0022	0	4	17	5	26	1	2	15	9	27
Youville Hospital 22-2000	0	6	13	7	26	0	2	17	14	33
Lake Shore Hospital 30-4002	0	3	10	3	16	0	0	2	0	2
Butler Hospital 41-4000	0	3	11	9	23	0	0	3	2	5
Landmark Medical 41-0011	0	3	8	3	14	0	4	7	13	24
Gifford Memorial 47-0004	1	4	7	1	13	0	3	4	4	11
REGION II										
Christ Hospital	1	3	9	1	14	0	4	9	0	13

APPENDIX B

FY 1990 SAMPLE VALIDATION SURVEYS DEFICIENCY FINDINGS

	JOINT COMMISSION ACCREDITATION DEFICIENCY FINDINGS					HCFA CERTIFICATION DEFICIENCY FINDINGS				
HOSPITAL	CONDITIONS	STANDARDS	ELEMENTS	LSC	TOTAL	CONDITIONS	STANDARDS	ELEMENTS	LSC	TOTAL
31-0016										
Holy Name Hospital 31-0008	1	3	9	1	14	0	5	5	0	10
Jersey City Hospital 31-0074	1	2	12	13	28	0	5	10	0	15
Morristown Memorial 31-0015	0	3	9	1	13	1	4	6	0	11
Wm Kessler Memorial 31-0088	0	4	8	1	13	0	0	0	0	0
Benjamin Rush Center 33-4023	0	2	7	1	10	0	6	7	3	16
Dobbs Ferry Hospital 33-0036	0	4	12	8	24	0	0	5	6	11
Highland Hospital 33-0164	0	5	7	0	12	1	2	16	0	19
Albert Lee Memorial 33-0075	1	4	5	1	11	0	2	18	0	20
Long Island Hospital 33-0152	0	5	11	9	25	2	6	12	21	41
Mercy Hospital 33-0279	0	6	6	1	13	0	10	46	0	56
Schuyler Hospital 33-0062	1	5	4	0	10	0	0	0	0	0
Yonkers General 33-0122	0	7	9	1	17	0	3	3	0	3
REGION III										
Beebe Medical 08-0007	0	4	8	2	14	0	1	1	1	3
DC General Hospital 09-0007	0	4	4	0	8	1	3	12	8	24
Johns Hopkins Hospital 21-0009	0	6	6	12	24	0	6	15	68	89
Univ. of MD Hospital 21-0002	0	3	4	0	7	0	5	21	36	62

APPENDIX B

FY 1990 SAMPLE VALIDATION SURVEYS DEFICIENCY FINDINGS

	JOINT COMMISSION ACCREDITATION DEFICIENCY FINDINGS					HCFA CERTIFICATION DEFICIENCY FINDINGS				
HOSPITAL	CONDITIONS	STANDARDS	ELEMENTS	LSC	TOTAL	CONDITIONS	STANDARDS	ELEMENTS	LSC	TOTAL
Chester County Hospital 39-0179	0	3	8	4	15	1	2	14	16	33
Columbia Hospital 39-0200	0	7	18	3	28	1	1	5	8	15
Conemaugh Valley Memorial 39-0110	0	5	10	1	16	1	1	1	18	21
Jeanes Hospital 39-0080	0	3	8	4	15	0	0	7	39	46
Lock Haven Hospital 39-0071	0	2	5	0	7	0	0	2	10	12
Meadville Medical Center 39-0113	0	4	7	5	16	0	0	0	1	1
Shadyside Hospital 39-0055	0	5	6	7	18	0	0	1	8	9
St Vincent Health Center 39-0009	1	4	11	0	16	1	2	0	8	11
Sunbury Community 39-0084	0	2	4	0	6	0	0	0	14	14
Titusville Hospital 39-0122	0	3	10	1	14	0	1	1	4	6
Fair Oaks Hospital 49-0101	0	3	8	0	11	1	1	0	2	4
Fauquier Hospital 49-0023	0	3	2	1	6	0	0	0	6	6
Prince Williams Hospital 49-0045	0	4	6	1	11	0	0	1	7	8
Twin County Community 49-0115	0	3	6	0	9	0	0	4	17	21
Bluefield Regional 51-0071	1	4	7	0	12	0	1	26	6	33
HCA River Park Hospital 51-4008	0	3	11	8	22	0	6	14	15	35
Potomac Valley Hospital 51-0061	0	5	14	3	22	0	2	21	10	33

APPENDIX B

FY 1990 SAMPLE VALIDATION SURVEYS DEFICIENCY FINDINGS

	JOINT COMMISSION ACCREDITATION DEFICIENCY FINDINGS					HCFA CERTIFICATION DEFICIENCY FINDINGS				
HOSPITAL	CONDITIONS	STANDARDS	ELEMENTS	LSC	TOTAL	CONDITIONS	STANDARDS	ELEMENTS	LSC	TOTAL
REGION IV										
Boaz Albertville Medical 01-0005	1	2	9	1	13	0	0	1	7	8
Central AL Medical Center 01-0097	0	4	14	1	19	0	0	1	7	8
Humana Hospital Enterprise 01-0049	0	2	3	0	5	0	0	1	10	11
S. Baldwin Hospital 01-0083	1	4	9	1	15	0	1	1	15	17
Edward White Hospital 10-0239	1	2	6	2	11	0	0	7	8	15
Holmes Regional Medical 10-0019	1	3	3	1	8	0	0	0	21	21
Holy Cross Hospital 10-0073	0	4	6	9	19	0	4	10	7	21
Humana Hospital Daytona 10-0229	0	3	4	0	7	0	0	0	0	0
HCA L W Blake Hospital 10-0213	0	2	3	0	5	0	0	0	0	0
Palmview Hospital 10-4006	1	4	7	0	12	0	0	0	4	4
St Cloud Hospital 10-0074	0	5	6	1	12	0	1	4	11	16
Fish Memorial Hospital 10-0014	1	2	12	0	15	0	0	2	0	2
Wuesthoof Memorial 10-0092	0	3	9	0	12	0	0	1	19	20
Memorial Medical Center 11-0036	0	1	4	0	5	0	0	0	25	25
Stephens County Hospital 11-0032	1	4	14	18	37	2	5	20	0	27
Tanner Memorial Center 11-0011	1	5	14	4	24	0	0	3	7	10
Tanner Medical Center 11-0015	0	2	8	0	10	0	0	6	2	8

APPENDIX B

FY 1990 SAMPLE VALIDATION SURVEYS DEFICIENCY FINDINGS

	JOINT COMMISSION ACCREDITATION DEFICIENCY FINDINGS					HCFA CERTIFICATION DEFICIENCY FINDINGS				
HOSPITAL	CONDITIONS	STANDARDS	ELEMENTS	LSC	TOTAL	CONDITIONS	STANDARDS	ELEMENTS	LSC	TOTAL
University Hospital 11-0028	0	2	17	21	40	0	0	4	25	29
Central Baptist Hospital 18-0103	0	3	5	9	17	3	2	2	7	14
Murray-Calloway Hospital 18-0027	2	4	7	4	17	3	5	5	5	18
Delta Medical Center 25-0082	1	7	7	5	20	0	3	14	23	40
Doctors Hospital 25-0129	1	2	6	2	11	1	0	7	8	16
Gulf Oaks Hospital 25-4003	1	6	12	1	20	0	0	1	2	3
Singing River Hospital 25-0040	1	2	1	0	4	0	2	7	16	25
Beaufort County Hospital 34-0038	0	4	7	3	14	0	2	8	22	32
C. A. Cannon Memorial 34-0005	0	5	5	2	12	0	1	3	1	5
Margaret Pardee Hospital 34-0017	0	2	7	11	20	0	1	4	2	7
University Of NC Hospital 34-0061	1	5	3	2	11	0	1	1	38	40
Charter Rivers Hospital 42-4008	0	0	6	0	6	0	0	0	0	0
Florence General Hospital 42-0040	0	7	5	2	14	0	0	7	7	14
Henry County General 44-0132	1	3	13	0	17	1	3	3	4	11
McNairy County General 44-0051	0	2	5	0	7	0	0	0	3	3
Takoma Adventist Hospital 44-0050	1	2	7	0	10	1	1	6	4	12

APPENDIX B

FY 1990 SAMPLE VALIDATION SURVEYS DEFICIENCY FINDINGS

	JOINT COMMISSION ACCREDITATION DEFICIENCY FINDINGS					HCFA CERTIFICATION DEFICIENCY FINDINGS				
HOSPITAL	CONDITIONS	STANDARDS	ELEMENTS	LSC	TOTAL	CONDITIONS	STANDARDS	ELEMENTS	LSC	TOTAL
REGION V										
Christ Hospital 14-0208	0	2	5	0	7	1	8	14	19	41
Galena-Strauss Hospital 14-0074	1	4	4	0	9	0	7	12	11	30
Illini Community Hospital 14-0139	0	2	11	2	15	0	4	8	9	21
Kewanee Hospital 14-0036	0	4	10	4	18	0	1	9	0	10
Mason District Hospital 14-0112	0	3	5	3	11	0	3	15	10	28
Memorial Hospital 14-0164	0	2	5	0	7	0	5	16	9	30
Ressurection Medical Center 14-0117	0	4	10	4	18	1	3	18	28	50
St Anthony Health Center 14-0052	0	4	5	2	11	0	5	15	24	44
Memorial Hospital of MI 15-0077	1	4	4	3	12	0	1	6	10	17
North Clark Community 15-0134	0	3	11	9	23	0	1	2	0	3
St Elizabeth Hospital 15-0003	0	3	5	1	9	0	1	8	0	9
St Francis Hospital 15-0033	0	3	8	0	11	0	3	6	0	9
St Johns Medical Center 15-0088	0	4	2	0	6	0	4	7	1	12
White County Memorial 15-0036	4	17	37	15	73	0	2	9	16	27
Caro Community Hospital 23-0235	0	4	8	1	13	0	0	7	3	10
Charlevoix Area Hospital 23-0124	1	6	18	0	25	0	4	13	7	24
Eaton Rapids Community 23-0153	0	6	12	1	19	1	2	16	3	22

APPENDIX B

FY 1990 SAMPLE VALIDATION SURVEYS DEFICIENCY FINDINGS

	JOINT COMMISSION ACCREDITATION DEFICIENCY FINDINGS					HCFA CERTIFICATION DEFICIENCY FINDINGS				
HOSPITAL	CONDITIONS	STANDARDS	ELEMENTS	LSC	TOTAL	CONDITIONS	STANDARDS	ELEMENTS	LSC	TOTAL
Henry Ford Hospital 23-0053	0	3	6	0	9	0	1	4	7	12
Heritage Hospital 23-0270	0	4	15	0	19	0	1	6	3	10
Mid-MI Regional Medical 23-0189	0	1	8	6	15	0	2	3	0	5
Paul Oliver Memorial 23-0062	0	5	11	0	16	1	1	12	0	14
Samaritan Health Center 23-0147	1	6	21	0	28	0	2	12	2	16
St Elizabeth Hospital 24-0008	0	5	8	2	15	2	10	19	5	36
St Peter Regional 24-4004	0	3	5	3	11	0	0	3	3	6
Tracy Municipal Hospital 24-0009	0	6	11	4	21	1	3	10	4	18
Brown County Hospital 36-0116	0	3	6	2	11	0	3	4	2	9
Flower Hospital 36-0074	1	5	8	3	17	0	3	11	4	18
Good Samaritan Hospital 36-0039	0	2	1	0	3	0	0	2	8	10
Hardin Memorial Hospital 36-0176	0	4	6	1	11	0	3	9	0	12
Lorain Community Hospital 36-0172	3	9	21	4	37	0	1	4	4	9
Mary Rutan Hospital 36-0197	0	2	4	0	6	0	2	4	3	9
Oak Hill Community Medical 36-0050	0	5	7	1	13	0	6	8	9	23
Joel Pomerene Memorial 36-0148	1	3	12	0	16	0	0	2	9	11
St Alexis Hospital 36-0049	0	6	2	0	8	0	0	1	6	7
Clintonville Community 52-0012	0	5	3	4	12	0	1	4	5	10

APPENDIX B

FY 1990 SAMPLE VALIDATION SURVEYS DEFICIENCY FINDINGS

	JOINT COMMISSION ACCREDITATION DEFICIENCY FINDINGS					HCFA CERTIFICATION DEFICIENCY FINDINGS				
HOSPITAL	CONDITIONS	STANDARDS	ELEMENTS	LSC	TOTAL	CONDITIONS	STANDARDS	ELEMENTS	LSC	TOTAL
Fox Valley Hospital 52-4031	6	8	21	24	59	0	1	2	0	3
Iowa County Memorial 52-0032	0	4	4	0	8	1	0	4	20	25
Prairie Du Chien Memorial 52-0134	0	3	3	0	6	0	0	4	6	10
REGION VI										
Drew Memorial Hospital 04-0051	2	8	19	15	44	4	15	44	1	64
Byrd Memorial Hospital 19-0164	1	7	17	1	26	1	4	19	1	25
Moorehouse General Hospital 19-0116	0	4	4	1	9	1	6	11	24	42
Parkland Hospital 19-4013	0	2	11	2	15	0	0	0	0	0
Pendleton Memorial Hospital 19-0124	0	3	8	2	13	0	0	0	0	0
Slidell General Hospital 19-0040	0	4	7	0	11	0	1	7	5	13
Sun Crest Hospital 32-4006	0	3	2	1	6	0	0	0	0	0
Clinton Regional Hospital 37-0029	0	4	14	26	44	0	5	4	7	16
Commanche Memorial Hospital 37-0056	0	6	9	7	22	1	1	16	12	30
Pauls Valley General 37-0156	0	6	15	10	31	0	3	8	2	13
Brookhaven Hospital 37-4012	0	6	15	0	21	0	0	0	0	0
Brackenridge Hospital 45-0124	0	4	5	1	10	0	7	16	9	32
Doctor's Hospital East Loop 45-0259	0	3	4	0	7	0	9	32	11	52

APPENDIX B

FY 1990 SAMPLE VALIDATION SURVEYS DEFICIENCY FINDINGS

	JOINT COMMISSION ACCREDITATION DEFICIENCY FINDINGS					HCFA CERTIFICATION DEFICIENCY FINDINGS				
HOSPITAL	CONDITIONS	STANDARDS	ELEMENTS	LSC	TOTAL	CONDITIONS	STANDARDS	ELEMENTS	LSC	TOTAL
Cypress Fairbanks Medical 45-0716	0	1	5	0	6	0	0	0	0	0
HCA Red River Hospital 45-4018	0	5	13	3	21	0	0	0	0	0
Houston County Hospital 45-0580	1	4	14	0	19	2	10	26	8	46
Methodist Hospital 45-0755	0	4	7	0	11	0	6	17	5	28
Palo Duro Hospital 45-0652	0	4	10	1	15	1	2	17	0	20
San Antonio Warm Springs 45-3035	0	1	3	3	7	0	1	11	5	17
Scenic Mountain Medical 45-0653	0	5	9	3	17	0	3	19	9	31
Scott & White Memorial 45-0054	0	2	3	0	5	1	2	11	8	22
St Paul Medical Center 45-0044	0	1	2	0	3	0	0	0	0	0
Woodland Heights Medical 45-0484	0	5	12	1	18	3	9	28	8	48
REGION VII										
Finley Hospital 16-0117	0	3	6	2	11	0	5	14	0	19
Knoxville Community Hospital 16-0114	0	5	15	7	27	0	0	0	0	0
Skiff Medical Center 16-0032	1	6	15	14	36	0	0	0	0	0
St Josephs Mercy Hospital 16-0020	1	5	6	2	14	0	4	17	0	21
Coffeyville Regional 17-0145	1	3	16	12	32	0	0	17	0	17
Lawrence Memorial Hospital 17-0137	1	6	7	6	20	0	1	6	0	7
St Marys Health Center 17-0007	0	4	15	0	19	0	0	0	0	0

APPENDIX B

FY 1990 SAMPLE VALIDATION SURVEYS DEFICIENCY FINDINGS

	JOINT COMMISSION ACCREDITATION DEFICIENCY FINDINGS					HCFA CERTIFICATION DEFICIENCY FINDINGS				
HOSPITAL	CONDITIONS	STANDARDS	ELEMENTS	LSC	TOTAL	CONDITIONS	STANDARDS	ELEMENTS	LSC	TOTAL
Bethesda General Hospital 26-0042	0	2	6	0	8	0	2	11	0	13
Farmington Regional 26-0163	0	5	8	7	20	1	1	5	0	7
Memorial Community Hospital 26-0047	0	5	7	1	13	0	3	4	0	7
St Francis Medical Center 26-0183	0	4	5	0	9	0	0	9	0	9
Hastings Regional Center 28-4002	1	3	12	0	16	0	0	0	0	0
Lutheran Medical Center 28-0085	0	6	9	2	17	0	1	10	0	11
St Elizabeth Community 28-0020		0	3	6	6	15	0	1	3	0
REGION VIII										
Craig Hospital 06-0101	1	4	6	3	14	2	2	4	18	26
Humana Mountain View 06-0065	0	2	4	0	6	0	1	8	6	15
Platte Valley Medical 06-0004	0	3	8	3	14	0	1	15	3	19
Holy Rosary Hospital 27-0002	0	7	11	1	19	0	0	0	0	0
Glendive Medical Center 27-0048	0	5	7	6	18	0	1	3	14	18
Trinity Medical Center 35-0043	1	4	10	1	16	0	0	7	2	9
Unity Hospital 35-0047	0	3	8	0	11	0	0	0	1	1
Huron Regional Medical 43-0011	0	7	13	4	24	0	1	21	12	34
Sacred Heart Hospital 43-0012	0	3	5	1	9	0	1	15	13	29
University of Utah 46-0009	1	0	5	1	7	0	4	9	9	22

APPENDIX B

FY 1990 SAMPLE VALIDATION SURVEYS DEFICIENCY FINDINGS

	JOINT COMMISSION ACCREDITATION DEFICIENCY FINDINGS					HCFA CERTIFICATION DEFICIENCY FINDINGS				
HOSPITAL	CONDITIONS	STANDARDS	ELEMENTS	LSC	TOTAL	CONDITIONS	STANDARDS	ELEMENTS	LSC	TOTAL
Wasatch Canyons Hospital 46-4008	0	2	2	0	4	0	2	2	6	10
Riverton Memorial Hospital 53-0008	0	9	20	6	35	3	6	17	0	26
Star Valley Hospital 53-0023	0	3	6	3	12	1	7	15	0	23
REGION IX										
Tucson Psych Institute 03-4003	0	4	11	8	23	0	0	0	12	12
Coast Plaza Medical Center 05-0219	1	3	4	6	14	0	0	0	0	0
Corcoran District Hospital 05-0349	1	8	18	8	35	0	3	10	5	18
Encino Hospital 05-0158	0	5	11	15	31	0	5	14	7	26
Feather River Hospital 05-0225	1	6	12	1	20	0	5	17	7	29
George Mee Memorial Hospital 05-0189	1	8	14	10	33	0	0	0	0	0
Kaiser Founddation Hospital 05-0512	1	1	6	1	9	0	3	19	19	39
Los Altos Hospital 05-4085	1	3	8	8	20	0	4	15	0	19
Menifee Valley Medical 05-0684	0	3	17	22	42	0	7	18	3	28
Palomar Medical Center 05-0115	1	2	13	9	25	0	2	17	9	28
Parkview Community Hospital 05-0102	1	6	7	8	22	0	3	17	0	20
Pomerado Hospital 05-0636	0	6	8	4	18	0	0	0	0	0
Washington Hospital 05-0401	2	5	12	5	24	4	6	28	13	51
Western Medical Anaheim 05-0594	0	6	23	11	40	0	4	17	19	40

APPENDIX B

FY 1990 SAMPLE VALIDATION SURVEYS DEFICIENCY FINDINGS

	JOINT COMMISSION ACCREDITATION DEFICIENCY FINDINGS					HCFA CERTIFICATION DEFICIENCY FINDINGS				
HOSPITAL	CONDITIONS	STANDARDS	ELEMENTS	LSC	TOTAL	CONDITIONS	STANDARDS	ELEMENTS	LSC	TOTAL
Wilcox Memorial Hospital 12-0014	0	2	3	2	7	0	2	1	3	6
REGION X										
Mt Edgecumbe Hospital 02-0027	1	6	10	7	24	0	1	8	5	14
Bingham Memorial Hospital 13-0022	0	4	16	7	27	0	0	13	11	24
Cassia Memorial Hospital 13-0026	0	2	2	5	9	0	0	0	9	9
Pacific Gateway Hospital 38-4006	1	6	11	5	23	0	0	3	6	9
Providence Medical Center 38-0061	0	3	8	1	12	0	2	6	4	12
Santiam Memorial 38-0056	0	3	5	17	25	0	0	7	7	14
Auburn General Hospital 50-0015	0	4	21	6	31	0	1	6	4	11
Swedish Hospital 50-0027	1	0	10	0	11	0	0	10	8	18
S. W. Washington Medical 50-0050	0	2	4	6	12	0	0	0	3	3

APPENDIX C

SAMPLE VALIDATION SURVEYS - VALIDATION DECISIONS BY SURVEY PERIOD

ALLEGATION INVESTIGATION SURVEY DECISIONS	FY 1989		FY 1990		ALL PREVIOUS REPORT PERIODS (INCLUDING FY 1989)	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
Hospitals in compliance	110	71.0	144	74.2	666	52.0
Hospitals out of compliance	45	29.0	50	25.8	615	48.0
Total Surveys performed	155	100.0	194	100.0	1281	100.0
REASONS FOR NONCOMPLIANCE	**NUMBER**	**PERCENT**	**NUMBER**	**PERCENT**	**NUMBER**	**PERCENT**
Hospitals out of compliance with Life Safety Code only	0	0.0	11	22	302	49.1
Hospitals out of compliance with Life Safety Code and at least one Condition of Participation	17	17.8	11	22	165	26.8
Hospitals out of compliance for reasons other than Life Safety Code	28	62.2	28	56.0	148	24.1
TOTAL	45	100	50	100	615	100

APPENDIX D

SAMPLE VALIDATION SURVEYS
FREQUENCY OF UNMET MEDICARE CONDITIONS IN HOSPITALS FY1989 AND FY1990

Condition of Participation		FY1990 (n = 155) Frequency	FY1990 (n = 155) Percent	FY1989 (n = 98) Frequency	FY1989 (n = 98) Percent
Compliance with Federal, State and Local Laws	482.11	1	0.5	1	0.6
Governing Body	482.12	2	1.0	6	3.9
Quality Assurance	482.21	10	5.2	17	11
Medical Staff	482.22	2	1.0	5	3.2
Nursing Services	482.23	1	0.5	4	2.6
Medical Record Services	482.24	1	0.5	3	1.9
Pharmaceutical Services	482.25	3	1.5	5	3.2
Radiologic Services	482.26	0	0	0	0
Laboratory Services	482.27	8	4.1	12	7.7
Food and Dietetic Services	482.28	1	0.5	4	2.6
Physical Environment	482.41	12	6.2	17	11
Infection Control	482.42	10	5.2	3	1.9
Surgical Services	482.51	1	0.5	1	0.6
Anesthesia Services	482.52	0	0	0	0
Nuclear Medicine Services	482.53	0	0	0	0
Outpatient Services	482.54	1	0.5	3	1.9
Emergency Services	482.55	1	0.5	1	0.6
Rehabilitation Services	482.56	0	0	3	1.9
Respiratory Care Services	482.57	5	2.6	3	1.9
*Life Safety Code		22	11.3	17	11

*The requirement that a hospital be in compliance with the provisions of the Life Safety Code (LSC) is contained in Condition of Participation 482.41 - Physical Environment. For purposes of this report, however, LSC is reported separately because it is a separate survey process.

APPENDIX E

SAMPLE VALIDATION SURVEYS AND ACCREDITATION SURVEYS
FREQUENCY OF UNMET MEDICARE CONDITIONS IN HOSPITALS FOR FY1990

Condition of Participation		Validation Surveys Frequency	Validation Surveys Percent	Accreditation Surveys Frequency	Accreditation Surveys Percent
Compliance with Federal, State and Local Laws	482.11	1	0.5	3	1.5
Governing Body	482.12	2	1.0	0	0
Quality Assurance	482.21	10	5.2	27	13.9
Medical Staff	482.22	2	1.0	1	0.5
Nursing Services	482.23	1	0.5	2	1.0
Medical Record Services	482.24	1	0.5	1	0.5
Pharmaceutical Services	482.25	3	1.5	1	0.5
Radiologic Services	482.26	0	0	0	0.0
Laboratory Services	482.27	8	4.1	0	0.0
Food and Dietetic Services	482.28	1	0.5	1	0.5
Physical Environment	482.41	12	6.2	11	5.7
Infection Control	482.42	10	5.2	19	9.8
Surgical Services	482.51	1	0.5	1	0.5
Anesthesia Services	482.52	0	0	1	0.5
Nuclear Medicine Services	482.53	0	0	2	1.0
Outpatient Services	482.54	1	0.5	1	0.5
Emergency Services	482.55	1	0.5	1	0.5
Rehabilitation Services	482.56	0	0	1	0.5
Respiratory Care Services	482.57	5	2.6	0	0.0
*Life Safety Code		22	11.3	**	

*The requirement that a hospital be in compliance with the provisions of the Life Safety Code (LSC) is contained in Condition of Participation 482.41 - Physical Environment. For purposes of this report, however, LSC is reported separately because it is a separate survey process.

**There are no percent or frequency data listed for LSC accreditation surveys due to the Joint Commissions system problems.

APPENDIX F

FY1990 ALLEGATION INVESTIGATION SURVEYS
HOSPITALS PLACED UNDER STATE AGENCY SURVEILANCE
35 HOSPITALS

HOSPITAL	NUMBER OF BEDS	HCFA SURVEY DATE	DEEMED STATUS REMOVED	DEEMED STATUS RESTORED	CONDITIONS NOT MET
REGION I					
22-0036 St. Elizabeth Boston, MA	350	12/06/89	12/08/89	04/03/90	PE
22-2014 Mattapan Boston, MA	151	01/05/90	02/06/90	03/28/90	PE, I
47-0016 Rockingham Memorial Bellows Falls, VT	xxx	03/13/90	04/02/90	09/12/90	E
REGION III					
21-0016 Washington Adventist Takoma Park, MD	300	11/02/89	11/24/89	05/11/90	G, Q, M, R
REGION IV					
11-0115 Georgia Baptist Atlanta, GA	523	07/17/90	07/24/90	11/15/90	G, Q, M, MR, O
11-0131 Atlanta Atlanta, GA	xxx	06/12/90	06/14/90	Involuntary Termination 07/05/90	F, G, Q, M, A
18-4004 Eastern State Lexington, KY	323	11/17/89	02/01/90	06/27/90	Q, PE
44-0136 Humana-McFarland Lebanon, TN	159	05/18/90	06/07/90	08/18/90	N, PE, I

Letter Code for Conditions Out of Compliance

F	- Federal, State, and local laws	L	- Laboratory Services	A	- Anesthesia Services
G	- Governing Body	PE	- Physical Environment	NM	- Nuclear Medicine
Q	- Quality Assurance	MR	- Medical Record Services	O	- Outpatient Services
M	- Medical Staff	FD	- Food and Dietetic Services	E	- Emergency Services
N	- Nursing Services	I	- Infection Control	RS	- Rehabilitation Services
P	- Pharmaceutical Services	S	- Surgical Services	RC	- Respiratory Care Services
R	- Radiologic Services	LSC	- Life Safety Code	FT	- Fatal Transfusion

APPENDIX F

FY1990 ALLEGATION INVESTIGATION SURVEYS
HOSPITALS PLACED UNDER STATE AGENCY SURVEILANCE
35 HOSPITALS

HOSPITAL	NUMBER OF BEDS	HCFA SURVEY DATE	DEEMED STATUS REMOVED	DEEMED STATUS RESTORED	CONDITIONS NOT MET
REGION V					
14-0126 Covenant Med Ctr Champaign, IL	268	11/30/89	02/22/90	05/22/90	G, I, S
14-2006 Vencor Sycamore, IL	49	04/12/90	04/17/90	05/20/90	N, E
REGION VI					
37-4002 Eastern State Vinita, OK	296	08/07/90	08/22/90	01/09/91	N, PE
45-0289 Harris County Houston, TX	835	08/27/90	09/13/90	Pending	Q
45-0423 AMI Twelve Oaks Houston, TX	220	08/24/90	09/18/90	Pending	Q, P
45-4075 Henderson Memorial Henderson, TX	62	10/26/89	11/14/89	04/13/90	Q, N, L
45-0539 Central Plains Reg Plainview, TX	93	11/21/89	12/19/89	05/03/90	L
45-0544 Parkway Houston, TX	222	12/06/89	12/27/89	07/30/90	N, F, Q, P, E

Letter Code for Conditions Out of Compliance

F - Federal, State, and local laws
G - Governing Body
Q - Quality Assurance
M - Medical Staff
N - Nursing Services
P - Pharmaceutical Services
R - Radiologic Services
L - Laboratory Services
PE - Physical Environment
MR - Medical Record Services
FD - Food and Dietetic Services
I - Infection Control
S - Surgical Services
LSC - Life Safety Code
A - Anesthesia Services
NM - Nuclear Medicine
O - Outpatient Services
E - Emergency Services
RS - Rehabilitation Services
RC - Respiratory Care Services
FT - Fatal Transfusion

APPENDIX F

FY1990 ALLEGATION INVESTIGATION SURVEYS
HOSPITALS PLACED UNDER STATE AGENCY SURVEILANCE
35 HOSPITALS

HOSPITAL	NUMBER OF BEDS	HCFA SURVEY DATE	DEEMED STATUS REMOVED	DEEMED STATUS RESTORED	CONDITIONS NOT MET
45-0610 Memorial City Med Ctr Houston, TX	520	01/12/90	01/29/90	09/21/90	Q, N, FD
45-0729 Lake Cliff Dallas, TX	36	04/26/90	05/11/90	11/15/90	M, Q, PE, L, R
45-0759 Community Tyler, TX	60	12/07/89	12/27/89	05/01/90	G, Q, I
45-4059 Willowbrook Waxahachie, TX	102	10/12/89	11/29/89	01/08/90	F
REGION VII 17-0014 Ransom Memorial Ottawa, KS	65	06/05/90	06/15/90	10/18/90	L
REGION VIII 06-0071 Delta County Mem Delta, CO	49	04/19/90	05/02/90	Pending	F, PE

Letter Code for Conditions Out of Compliance

F	- Federal, State, and local laws	L	- Laboratory Services	A	- Anesthesia Services
G	- Governing Body	PE	- Physical Environment	NM	- Nuclear Medicine
Q	- Quality Assurance	MR	- Medical Record Services	O	- Outpatient Services
M	- Medical Staff	FD	- Food and Dietetic Services	E	- Emergency Services
N	- Nursing Services	I	- Infection Control	RS	- Rehabilitation Services
P	- Pharmaceutical Services	S	- Surgical Services	RC	- Respiratory Care Services
R	- Radiologic Services	LSC	- Life Safety Code	FT	- Fatal Transfusion

APPENDIX F

FY1990 ALLEGATION INVESTIGATION SURVEYS
HOSPITALS PLACED UNDER STATE AGENCY SURVEILANCE
35 HOSPITALS

HOSPITAL	NUMBER OF BEDS	HCFA SURVEY DATE	DEEMED STATUS REMOVED	DEEMED STATUS RESTORED	CONDITIONS NOT MET
REGION IX					
03-0064 University Med Ctr Tucson, AZ	300	09/29/90	10/17/90	02/06/91	LSC
03-0065 Desert Samaritan Mesa, AZ	345	02/13/90	03/05/90	06/22/90	L
05-0019 Avenal District Avenal, CA	28	01/26/90	03/09/90	04/06/90	PE
05-0096 Doctors Hospital West Covina, CA	60	04/03/90	06/01/90	09/07/90	G
05-0113 San Mateo County San Mateo, CA	145	03/28/90	04/16/90	Pending	LSC
05-0320 Highland General Oakland, CA	300	03/30/90	04/12/90	Pending	G, M, MR, LSC
05-0447 Villa View Community San Diego, CA	xxx	09/13/90	10/05/90	Pending	Q, N
05-0497 Dos Palos Memorial Dos Palos, CA	17	01/18/90	02/28/90	05/09/90	Q, M, E, L
05-0512 Kaiser Foundation Hayward, CA	193	11/03/89	04/05/90	10/31/90	PE
05-0590 Methodist Sacramento, CA	150	10/13/89	11/29/89	02/23/90	L

Letter Code for Conditions Out of Compliance

F - Federal, State, and local laws
G - Governing Body
Q - Quality Assurance
M - Medical Staff
N - Nursing Services
P - Pharmaceutical Services
R - Radiologic Services
L - Laboratory Services
PE - Physical Environment
MR - Medical Record Services
FD - Food and Dietetic Services
I - Infection Control
S - Surgical Services
LSC - Life Safety Code
A - Anesthesia Services
NM - Nuclear Medicine
O - Outpatient Services
E - Emergency Services
RS - Rehabilitation Services
RC - Respiratory Care Services
FT - Fatal Transfusion

APPENDIX F

FY1990 ALLEGATION INVESTIGATION SURVEYS
HOSPITALS PLACED UNDER STATE AGENCY SURVEILLANCE
35 HOSPITALS

HOSPITAL	NUMBER OF BEDS	HCFA SURVEY DATE	DEEMED STATUS REMOVED	DEEMED STATUS RESTORED	CONDITIONS NOT MET
05-0641 East Los Angeles Doctor's Los Angeles, CA	128	02/22/90	03/28/90	04/26/90	M
05-0649 San Diego Physicians-Surgeons San Diego, CA	xxx	10/27/89	02/06/90	04/23/90	FD
REGION X					
50-0096 Ocean Beach Ilwaco, WA	25	04/06/90	04/12/90	05/11/90	N

Letter Code for Conditions Out of Compliance

F	- Federal, State, and local laws	L	- Laboratory Services	A	- Anesthesia Services
G	- Governing Body	PE	- Physical Environment	NM	- Nuclear Medicine
Q	- Quality Assurance	MR	- Medical Record Services	O	- Outpatient Services
M	- Medical Staff	FD	- Food and Dietetic Services	E	- Emergency Services
N	- Nursing Services	I	- Infection Control	RS	- Rehabilitation Services
P	- Pharmaceutical Services	S	- Surgical Services	RC	- Respiratory Care Services
R	- Radiologic Services	LSC	- Life Safety Code	FT	- Fatal Transfusion

APPENDIX G

ALLEGATION INVESTIGATIONS
FREQUENCY OF UNMET MEDICARE CONDITIONS IN HOSPITALS PLACED UNDER STATE AGENCY SURVEILLANCE
FY1990 (n = 35)

CONDITION OF PARTICIPATION	NUMBER	PERCENT
Compliance with Federal, State and Local Laws 482.11	4	11
Governing Body 482.12	7	20
Quality Assurance 482.21	13	37
Medical Staff 482.22	7	20
Nursing Services 482.23	8	23
Medical Record Services 482.24	2	6
Pharmaceutical Services 482.25	2	6
Radiologic Services 482.26	2	6
Laboratory Services 482.27	7	20
Food and Dietetic Services 482.28	2	6
Physical Environment 482.41	9	26
Infection Control 482.42	4	11
Surgical Services 482.51	1	3
Anesthesia Services 482.52	1	3
Nuclear Medicine Services 482.53	0	0
Outpatient Services 482.54	1	3
Emergency Services 482.55	4	11
Rehabilitation Services 482.56	0	0
Respiratory Care Services 482.57	0	0
Life Safety Code ..... 482.41(b) *	3	9

*The requirement that a hospital be in compliance with the provisions of the Life Safety Code (LSC) is contained in Condition of Participation 482.41 - Physical Environment. For purposes of this report, however, LSC is reported separately because it is a separate survey process.

APPENDIX H

ALLEGATION INVESTIGATION SURVEYS COMPLIANCE AND NONCOMPLIANCE DECISIONS

	FY 1989		FY 1990	
ALLEGATION INVESTIGATION SURVEY DECISIONS	NUMBER	PERCENT	NUMBER	PERCENT
Hospitals in compliance	525	90	600	95
Hospitals out of compliance	57	10	35	5
Surveys performed	582	100	695	100
REASONS FOR NONCOMPLIANCE	**NUMBER**	**PERCENT**	**NUMBER**	**PERCENT**
Hospitals out of compliance with Life Safety Code only	3	5	2	6
Hospitals out of compliance with Life Safety Code and at least one Condition of Participation	1	2	1	3
Hospitals out of compliance for reasons other than Life Safety Code	53	93	32	91
TOTAL	57	100	35	100

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